



IMPORTANT NOTICE OF 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 accidental 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 **Wesco Insurance Company Decision Point Review Plan** is available in hard copy by calling Procura Management Inc at 1-800-275-9485, and is also available at www.procura-inc.com.

The following diagnostic tests are subject to Decision Point Review for both identified and all other injuries:

- 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 (Needle EMG)
- 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 diagnostic tests, treatments, surgery, services, durable medical goods and non-medical products, devices, services and activities identified below, the patient's medical provider is required to submit prior notification to Procura Management Inc, Wesco Insurance Company's vendor. 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 co-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 as well as the facility length of stay and provider services associated with these services
- Non-emergency surgical procedures as well as the facility stay and the provider services associated with the surgery (performed in a hospital, freestanding surgery center office, etc.)
- All Non-Emergency inpatient and outpatient Psychological/Psychiatric Services
- Outpatient care for soft tissue/disc injuries of the insured person's neck, back and related structures not included within the diagnoses covered by the Care Path.
- Extended Care and Rehabilitation Facilities
- All Home Health Care
- CT Myelogram
- Discogram
- Non-Emergency Dental Restoration
- Treatment, testing and/or durable medical goods of Temporomandibular disorders and/or any oral facial syndrome
- Non-Emergency medical transportation with a round trip transportation expense in excess of \$75.00
- Durable Medical Goods, including orthotics and prosthetics that collectively exceed \$300.00 cost and/or monthly rental greater than 30 days
- Non-medical products, devices, services and activities and associated supplies, not exclusively used for medical purposes or as durable medical goods, with a cost of \$50.00 and/or monthly rental greater than 30 days, including but not limited to:
 1. vehicles
 2. modification to vehicles
 3. durable goods
 4. furnishings
 5. improvements or modifications to real or personal property
 6. fixtures
 7. recreational activities and trips
 8. leisure activities and trips
 9. spa/gym memberships
- 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 including but not limited to:
 1. acupuncture
 2. nerve blocks
 3. manipulation under anesthesia
 4. anesthesia when performed in conjunction with invasive techniques
 5. radio frequency/rhyzotomy
 6. narcotics, when prescribed for more than three (3) months
 7. biofeedback
 8. implantation of spinal stimulators or spinal pumps
 9. trigger point injections
 10. tens units (transcutaneous electrical nerve stimulation)

VOLUNTARY PRE-CERTIFICATION:

Insured persons and their 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 Decision Points and for Treatment, Diagnostic Testing or DME requiring precertification is not required.

EMERGENCY CARE:

Treatment obtained in emergency care as defined by N.J.A.C. 11:3-4.2, and / or within ten (10) days of the insured event, 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.

If your provider fails to request **decision point review** or **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.

HOW TO SUBMIT DECISION POINT/PRE-CERTIFICATION REQUESTS:

Decision Point / Pre-certification 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 received before or after business hours, on weekends and holidays will be handled on the next business day.

Properly Submitted requests

Your medical treating 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 www.procura-inc.com. Failure to submit the required documentation could result in a delay in receiving a final determination of your request. Properly submitted requests for decision point review and precertification must include the injured 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 and ICD-9 codes, diagnostic tests performed including the test findings, recommended tests, pre-existing conditions, CPT codes, and any additional information or documentation required to review the treatment/testing and/or DME request. When an improperly submitted request is received, Procura Management Inc will inform your treating provider what additional medical documentation or information is required. An administrative denial for failure to provide required medical documentation or information will be issued and will remain in effect until all requested information needed to process a review to determine medical necessity regarding the requested treatment/testing and/or DME is received.

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

Procura Management Inc shall respond to your treating 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 the treating provider within three (3) business days, you may continue with the test or treatment until our final determination is communicated to you or your treating provider.

If Wesco Insurance Company or Procura Management Inc is unable to make an informed determination based solely on the medical documentation, Wesco Insurance Company 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 (7) calendar days from the date that Procura or Wesco Insurance Company notified all required parties that an Independent Medical Examination will be scheduled unless the injured person agrees with Procura Management Inc or Wesco Insurance Company 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 pre-certification request will be submitted to the insured person in writing and to the health care provider in writing and by telephone within three (3) business days after the examination. Please note that reimbursement of the medically necessary treatment, testing or durable medical goods may proceed while the Independent Medical Examination is being scheduled and until the results are available and until you are notified that the treatment, testing or durable medical goods are not authorized. 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.

You are required to present photo identification to the examining provider at the time of the exam. If you are non-English speaking, then an interpreter must accompany you to the examination. If you must reschedule your appointment, you must contact Procura or Wesco Insurance Company within three (3) business days prior to the scheduled appointment.

In accordance with the AICRA Regulations, 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. If the injured person has two (2) or more unexcused failures to attend the scheduled exam or three (3) 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 treating 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.

An example of the injured person's three (3) total failures to attend the exam may include three (3) occurrences of any one of the following or three (3) occurrences of any combination of the following:

- Failure to provide the medical records and diagnostic films before or on the day of examination.
- Rescheduling of the examination for any reason even within the required three (3) business days prior to the examination appointment.
- Failure to present valid photo identification for the exam.
- Failure to be accompanied by an interpreter if the injured party is non-English speaking.
- Failure to present for any of the scheduled examination appointments for any reason.

Any denial of treatment or testing based on medical necessity shall be made by a physician or dentist. Reimbursement for expenses for medically necessary care is subject to the provisions of the auto insurance policy and New Jersey law including deductibles, co-payments, policy limits, and the medical fee schedule. In addition, reimbursement is subject to a determination that the care is for injuries caused by a covered accident.

VOLUNTARY NETWORK SERVICES

Currently, you have a 30% co-payment penalty for diagnostic imaging, electrodiagnostic testing and durable medical equipment (see list below) rendered or dispensed by a provider who is not within the PPO Network described below. Your copayment penalty for prescription drugs is \$10.00:

1. Magnetic Resonance Imagery (MRI);
2. Computer Assisted Tomography (CAT);
3. Electro diagnostic tests listed in 11:3-4.5 (b) 1-3, except when performed by the treating physician.
4. Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of \$300.00.

Eligible injured persons are encouraged, but not required, to obtain the noted service from one of the Procura's Network of providers. In accordance with N.J.A.C. 11:3-4. 4 (f) failure to use an approved network will result in an additional co-payment of 30% of the eligible charge.

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 payment is waived when accessing a network provider.

Procura Management Inc can recommend providers for the following:

1. Magnetic Resonance Imagery (MRI);
2. Computer Assisted Tomography (CAT);
3. Electro diagnostic tests listed in 11:3-4.5 (b) 1-3, except when performed by the treating physician;
4. Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of \$300.00;

Cypress Care will coordinate, any or all of the approved items listed in 1- 4 above, with a provider you have selected within the Procura network.

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 **precertification** as required in the Wesco Insurance Company Decision Point Review/Precertification plan will result in a 50% copayment penalty. This copayment penalty will be in addition to any co-payment stated in the schedule of your policy. Failure to submit clinically supported findings that support your decision point review or precertification request will result in a 50% copayment penalty. Copayments and deductibles will first be applied to the eligible charges and then penalties will be applied for failure to precertify.

ASSIGNMENT OF BENEFITS

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We, Wesco Insurance Company, may at our option, pay any medical expense benefits to the insured or their health care provider.

Benefits 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 and all precertification requirements. 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 and all pre-certification requirements.

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 and / or the injured party is not eligible for Wesco Insurance Company benefits;
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 our Decision Point Review Plan and Precertification processes;
5. a health care provider does not comply with the "Dispute Resolution" provisions in our approved Decision Point Review Plan, including utilization of the Internal Appeal process.

INTERNAL APPEAL PROCESS:

If Procura denies the request for certification of services, the clinical rationale for this determination is available upon written request. If the provider, or the insured would like to have the decision reconsidered, they can participate in Procura's Internal Appeal review process by notifying Procura Management Inc in writing of their intention to participate in the reconsideration process and simply fax the reconsideration to Procura at 610-631-7011 or by mailing to Procura at Procura Management Inc 2435 Boulevard of the Generals, Attention AIMS Appeal Dept, Norristown, PA 19403.

Requests for reconsideration must be made within 30 days from the date in which the adverse determination was made and must include the explanation / medical rationale for the request as well as supporting documentation. This process will afford the treating provider the opportunity to discuss the reconsideration with a Procura Medical Director. If the required reason and supporting documentation, for the reconsideration request, was not provided to Procura, the submitting party will be notified that the reconsideration will not be processed. In addition, Procura may request that additional necessary medical documentation and / or information be submitted in order to properly process the reconsideration; the reconsideration will not be processed until the requested documentation or information has been provided to Procura.

If the provider has accepted in an assignment of benefits, they are required to participate in this process prior to initiating arbitration or litigation. Submission of information identical to the initial material submitted in support of the request will not be accepted as a request for reconsideration. Provided that the required explanation / medical rationale and additional necessary medical information have been submitted, a response to the reconsideration request will be made within fourteen (14) days of receipt of the request.

For dispute of issues other than requests for decision point review and pre-certification, any treating provider who has accepted an assignment of benefits must submit a written request for an Internal Appeal specifying the issues in dispute accompanied by supporting documentation at least 21-days prior to initiating arbitration or litigation.

Dispute resolution - health care providers with a valid assignment of benefits

If we or any assignee seeking Personal Injury Protection benefits disagree as to the provision of benefits assigned, either party shall have the right to submit the matter to Alternate Dispute Resolution in accordance with N.J.A.C. 11:3-5. However, prior to submitting the matter to Alternate Dispute Resolution, the assignee must utilize our Internal Appeal Process as outlined in this Decision Point Review Plan approved by the Department of Banking and Insurance.

All appeals by assignees regarding decision point review, precertification, or payment of medical bills must be submitted to Procura Management Inc for reconsideration as described above in Internal Appeal Process Requirements. Any other disputes and any disputes not resolved through the foregoing Internal Appeal Process must also be submitted to Procura Management Inc for a Second Level Internal Appeal as follows:

To initiate a Second Level Internal Appeal, the assignee shall submit written notice of the dispute to Procura Management Inc which must include an explanation / medical rationale and additional necessary medical information to support the second level appeal.

The assignee shall set forth in the written notice the basis of the appeal and the facts underlying the dispute. The assignee shall include copies of all relevant supporting documents, including, but not limited to, any unpaid medical bills for medical expenses that may be in dispute.

All Second Level Internal Appeal requests will be reviewed within 30 days from receipt of the notice and all supporting documents. A final decision will be communicated to the assignee in writing within 30 days of receipt of the request. During this time, the assignee shall cooperate with us in the investigation of the dispute and negotiate in good faith with us in an effort to resolve the dispute amicably.

If, despite completion of the complete Internal Appeal Processes, 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. Any request for Alternate Dispute Resolution 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 <http://www.arb.-forum.com> www.nj-info@arb-forum.com.

If the assignee retains counsel to represent them during the appeal process, they do so strictly at their own expense. No counsel fees or costs incurred during the appeal process shall be compensable.

The assignee agrees to indemnify and hold us harmless for any legal fees and/or costs incurred by us as a result of the assignee's failure to utilize the Internal Appeal Process prior to fulfilling the Alternate Dispute Resolution requirements of the policy. To the extent permitted by law, the results of said Alternate Dispute Resolution processes shall be final and binding, with no right of appeal.

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.