DECISION POINT REVIEW/PRE-CERTIFICATION PLAN "PROVIDER LETTER"

Date (##/##/####)

Physician Name
Street Address
City, State, Zip

Claimant:
Claim Number:
Medlogix ID #:
Date of Accident:
Insured

Dear Provider:

This letter is to advise you that Consolidated Services Group, Inc. (CSG) is handling decision point review/precertification and medical service review of this claim for Foremost Insurance Company Grand Rapids, Michigan and/or Bristol West Insurance Group, your patient's no-fault insurance carrier. Pursuant to N.J.A.C. 11:3-4, you are required to notify us of those services you intend to perform on the patient, as hereinafter explained. Foremost Insurance Company Grand Rapids, Michigan and/or Bristol West Insurance Group have contracted with Consolidated Services Group, Inc. (the "PIP Vendor") for these purposes.

In accordance with N.J.A.C. 11:3-4.7(c) 3, a copy of the informational materials for policy holders, injured persons and providers approved by the New Jersey Department of Banking and Insurance, is available through Consolidated Services Group, Inc. website @ www.csg-inc.net.

Please note, no decision point or pre-certification requirements shall apply within 10 days of the insured event or to treatment administered in emergency care. This provision should not be construed so as to require reimbursement of tests and treatment that are not medically necessary.

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 (the "Department") has published standard courses of treatment, **Care Paths**, for soft tissue injuries of the neck and back, collectively referred to as the "Identified Injuries". 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**. In addition, the

administration of any test listed in N.J.A.C. 11:3-4.5(b) 1-10 also requires Decision Point Review, regardless of the diagnosis. If you fail to submit requests for Decision Point Reviews or fail to provide clinically supported findings that support the request, payment of your bills will result in a co-payment of 50% (in addition to any deductible or co-payment that applies under the policy) of the eligible charge for medically necessary services. The **Care Paths** and accompanying rules are available on the Internet at the Department's website at www.nj.gov/dobi/aicrapg.htm or can be obtained by contacting CSG @ 1 (877) 258-CERT (2378).

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 submit requests for the pre-certification of all the services listed below or fail to provide clinically supported findings that support the request, payment of your bills will result in a co-payment of 50% (in addition to any deductible or co-payment that applies under the policy) of the eligible charge for medically necessary services. You are encouraged to maintain communication with CSG on a regular basis as precertification requirements may change. Pre-certification is mandatory as to any of the following medical services once 10 days have elapsed since the accident:

(a) non-emergency inpatient and outpatient hospital care
(b) non-emergency surgical procedures
(c) extended care rehabilitation facilities
(d) 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 Paths
e) 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
(f) outpatient psychological/psychiatric testing and/or services
(g) all pain management services except as provided for identified injuries in accordance with decision point review
(h) home health care
(i) non-emergency dental restoration
(j) temporomandibular disorders; any oral facial syndrome
(k) infusion therapy
(l) Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of $75.00

HOW TO SUBMIT DECISION POINT REVIEW/PRE-CERTIFICATION REQUESTS

CSG Hours of Operation – 7:00 AM to 7:00 PM EST Monday through Friday (excluding legal holidays) In order for CSG to complete the review, you are required to submit all requests on the "Attending Physicians Treatment Plan" form as adopted by the DOBI. A copy of this form can be found on the DOBI web site www.nj.gov/dobi/aicrapg.htm, CSG's web site www.csg-inc.net or by contacting CSG @ (877) 258-CERT (2378).

Please return this completed form, along with a copy of your most recent/appropriate progress notes and the results of any tests relative to the requested services to CSG via fax at (856) 910-2501 or mail to

the following address: CSG, Inc., 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619, ATTN.: Pre-Certification Department. Its phone number is (877) 258-CERT (2378).

The review will be completed within three (3) business days of receipt of the necessary information and notice of the decision will be communicated to your office by telephone and/or confirmed in writing. If you are not notified within 3 business days, you may continue your test or course of treatment until such time as the final determination is communicated to you. Similarly, if an independent medical examination should be required, you may continue your tests or course of treatment until the results of the examination become available.

Denials of decision point review and pre-certification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist.

To clarify the CSG processing time, the definition of days is as follows: “Days” means calendar days unless specifically designated as business days.

1. A calendar and business day both end at the time of the close of business hours (7:00 PM EST Monday through Friday (excluding legal holidays).

2. In computing any period of time designated as either calendar or business days, the day from which the designated period of time begins to run shall not be included. The last day of a period of time designated as calendar or business day is to be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday or legal holiday.

3. Example: Response to a properly submitted provider request is due back no later than 3 business days from the date CSG receives the submission. CSG receives an Attending Provider Treatment Plan Form by facsimile transmission dated 1:00 PM EST on Wednesday February 6, 2013. Day one of the 3-buisness day period is Thursday, February 7, 2013. Since the 3rd day would be Saturday, February 9, 2013, CSG’s decision is due no later than close of business Monday, February 11, 2013.

INDEPENDENT MEDICAL EXAMS

If the need arises for CSG to utilize an independent medical exam during the decision point review/precertification process, the guidelines in accordance to 11:3-4.7(e) 1-7 will be followed. This includes but is not limited to: prior notification to the injured person or his or her designee, scheduling the exam within seven calendar days of the receipt of the attending physicians treatment plan form (unless the injured person agrees to extend the time period), having the exam conducted by a provider in the same discipline, scheduling the exam at a location reasonably convenient to the injured person, and providing notification of the decision within three business days after attendance of the exam

If the injured person has two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to the injured person or his or her designee, and all providers treating the injured person for the diagnosis (and related diagnosis) contained in the attending physicians 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 physicians treatment plan form will not be reimbursable as a consequence for failure to comply with the plan.

POSSIBLE OUTCOMES

The following are the possible outcomes of our review:

(a)The requested service is certified.

(b) If CSG receives information that, in their view, is insufficient to support the requested test or service, they will issue an administrative non-certification and will continue to non-cert the requested test or service until such time as they receive documentation sufficient to evaluate the request.

(c) In the event CSG feels a change in the requested test or service is advisable (whether in frequency, duration, intensity or place of service or treatment), they will notify your office of the modified results

(d) In the event CSG is unable to certify your request, your office will be notified of the results and a CSG Medical Director will be available through an internal reconsideration process to discuss the case with you. CSG may also request that the patient undergo an Independent Medical Examination. Any such exam will be scheduled in accordance with 11:3-4.7(e) 1-7 as stated In the Independent Medical Exams section above.

INTERNAL APPEAL PROCESS

The Internal Appeal Process shall be completed before filing arbitration. If you have accepted an assignment of benefits or have a power of attorney from the insured, the Internal Appeal Process must be followed prior to the initiation of any arbitration or litigation. The Internal Appeal Process is streamlined to address Treatment Requests Disputes as well as Other Disputes (those other than treatment requests). Appeals relating to Treatment Requests are to be submitted to CSG. Appeals relating to Other Disputes including bill payment are to be submitted to Bristol West Insurance.

The appeal process described below provides only one-level appeal prior to submitting the dispute to alternative dispute resolution or litigation. A provider cannot submit a pre-service appeal and then a post-service appeal on the same issue. The preapproval of the treatment and the reimbursement for that treatment are separate issues. A provider can submit a pre-service appeal for the treatment and then a post-service appeal for the reimbursement of that treatment.

Completion of the internal appeal process means timely submission of an appeal and receipt of the response prior to filing for alternate dispute resolution or litigation. Except for emergency care as defined in N.J.A.C. 11:3-4.2, any treatment that is the subject of the appeal that is performed prior to the receipt by the provider of the appeal decision shall invalidate the assignment of benefits.

If you retain counsel to represent you during the Internal Appeal Process, you do so strictly at your own expense. No reimbursement will be issued for counsel fees or any costs regardless of the outcome of the

appeal.

PRE-SERVICE APPEAL PROCESS

Per N.J.A.C. 11:3-4.7B, effective April 17, 2017, a pre-service appeal of a decision point review and/or precertification denial or modification must be submitted no later than thirty (30) days after receipt of a written denial or modification of requested services. If you have accepted an assignment of benefits, or have a power of attorney, you are required to participate in this process. Failure to participate timely in this process shall void the assignment of benefits and/or power of attorney.

Disputes concerning medical necessity of a denial or modification of a treatment request, are to be made as pre-service appeals. The pre-service appeals process must be completed prior to the performance or issuance of the requested service.

In accordance with N.J.A.C. 11:3-4.7B (c), appeals must be submitted on the pre-service appeal form approved by the New Jersey Department of Banking and Insurance (DOBI), available on the DOBI website: (http://www.state.nj.us/dobi/pipinfo/aicrapg.htm). The properly completed pre-service appeal form and any supporting documentation, must be submitted to CSG. In accordance with N.J.A.C.11:3-4.7B , a pre-service appeal decision will be provided to your health care provider within fourteen (14) calendar days from receipt of the properly completed pre-service appeal form and any supporting documents submitted by your health care provider or any documentation requested by us in order to complete our review. This process will afford you the opportunity to discuss the appeal with a "similar discipline" Medical Director or request an independent examination scheduled by CSG. Failure to submit a properly completed pre-service appeal form will result in an administrative denial. An incomplete submission and/or administrative denial shall not constitute acceptance within the required timeframe for pre-service appeals.

Pre-service appeals must be submitted directly to CSG, via fax at (856) 910-2501, or in writing at 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619. Pre-service appeals will only be considered valid if they are submitted to CSG at the fax number or address listed here.

POST-SERVICE APPEAL PROCESS

Effective April 17, 2017, if any payment or non-payment is unacceptable to you, the health care provider, Bristol West Insurance provides an Internal Appeal Process which is available for review of the decision to which you object. A post-service appeal must be submitted at least forty-five (45) days prior to initiating alternative dispute resolution pursuant to N.J.A.C. 11:3-5 or filing action in Superior Court.

In accordance with N.J.A.C. 11:3-4.7B,(c) appeals must be submitted on the post-service appeal form approved by the New Jersey Department of Banking and Insurance (DOBI), available on the DOBI website: (http://www.state.nj.us/dobi/pipinfo/aicrapg.htm). The properly completed post-service appeal form and any supporting documentation, must be submitted to the address or fax number listed below. In accordance with N.J.A.C.11:3-4.7B , a post-service appeal decision will be provided to you within thirty

(30) calendar days from receipt of the properly completed post-service appeal form and any supporting documents submitted by you or any documentation requested by us in order to complete our review. Failure to submit a properly completed post-service appeal form will result in an administrative denial. An incomplete submission and/or administrative denial shall not constitute acceptance within the required timeframe for post-service appeals.

The properly completed post-service appeal form and any supporting documentation, must be submitted to Bristol West Insurance via fax at (844) 570-8231, or via certified mail to: New Jersey Appeals Administrator, Bristol West Insurance, 400 Colonial Center Parkway, Suite 200, Lake Mary, FL 32746, Post service appeals will only be considered valid if they are submitted to the fax number or address listed here.

If you have accepted an assignment of benefits, or have a power of attorney, you are required to participate in this process. Failure to participate timely in this process shall void the assignment of benefits and/or power of attorney.

PIP DISPUTE RESOLUTION PROCESS

If there is any dispute (excluding coverage) that is not resolved by the Internal Appeal Process, it must be submitted through the Personal Injury Protection Dispute Process (N.J.A.C. 11:3-5). Requests for dispute resolution may include a request for review by a Medical Review Organization. We retain the right to file a Motion to remove any Superior Court action to the Personal Injury Protection Dispute Resolution Process pursuant to **N.J.S.A.** 39:6A-5.1. Failure to utilize the Internal Appeal Process prior to filing arbitration or litigation will invalidate an assignment of benefits.

ASSIGNMENTS OF BENEFITS

Please also note that, if you accept an assignment of benefits from the patient, you:

(a) agree to follow the requirements of our Decision Point Review Plan for making decision point review and precertification requests;
(b) shall hold the insured harmless for penalty co-payments imposed by us based on your failure to follow the requirements of our Decision Point Review Plan;
(c) agree to follow the Internal Appeal Process for disputes arising out of a request for Decision Point Review or Precertification;
(d) agree to follow the Internal Appeal Process for Other Disputes for any issues other than a decision related to a treatment request; and
(e) agree to submit disputes to PIP Dispute Resolution pursuant to N.J.A.C. 11:3-5. However, prior to submitting to PIP Dispute Resolution, you must comply with the requirements of (c) and (d) above.

Failure on the part of the provider to comply with (a), (b), (c), (d) and (e) above, will render any assignment of benefits null and void.

VOLUNTARY UTILIZATION PROGRAM

In accordance with N.J.A.C. 11:3-4.8(b) the plan includes a voluntary utilization program for:

1. Magnetic Resonance Imagery
2. Computer Assisted Tomography
3. The electro diagnostic tests listed in N.J.A.C. 11:3-4.5(b)1 through 3 except for needle EMGs, H-reflex and nerve conduction velocity (NVC) tests performed together by the treating physician
4. Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of $75.00
5. Services, equipment or accommodations provided by an ambulatory surgery facility

When one of the above listed services, tests or equipment is requested through the decision point review/precertification process, a detailed care plan evaluation letter containing the outcome of the review is sent to the injured person or his or her designee, and the requesting provider. In addition the notice will include how to acquire a list of available preferred provider networks to obtain the medically necessary services, tests or equipment requested. In accordance with N.J.A.C.11:3-4.4(g), failure to use an approved network will result in an additional co-payment not to exceed 30 percent of the eligible charge.

In addition to securing a list of preferred provider networks through the process outlined in the paragraph above, visit CSG's website @ www.csg-inc.net, contact CSG by phone @ (877) 258-CERT (2378), via fax @ (856) 910-2501, or in writing @ 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

Should you have any questions or require any further information not available through the websites, don't hesitate to contact us or CSG.

Sincerely,

Foremost Insurance Company Grand Rapids, Michigan
Bristol West Insurance Group
P.O. Box 31029 Independence, OH 44131-0029