Cumberland Mutual

Cumberland Insurance Company, Inc.
Decision Point Review Plan Requirements

Important Information about No-Fault Medical Coverage Also Known as Personal Injury Protection or PIP

The Automobile Insurance Cost Reduction Act became law in May 1998 and established certain obligations which must be satisfied so that coverage for medically necessary treatment, diagnostic testing and durable medical equipment arising from injuries sustained in an automobile accident may be provided. Failure to abide by the following obligation may affect the authorization of medical treatment, diagnostic testing, and durable medical equipment.

CARE PATHS/DECISION POINT REVIEW

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. A failure to submit requests for Decision Point Reviews or failure to provide clinically supported findings that support the request, payment of the associated medical 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 http://www.state.nj.us/dobi/pipinfo/aicrapg.htm or can be obtained by contacting Medlogix at (877) 258-CERT (2378).

MANDATORY PRE-CERTIFICATION

If an injured party does not have an *Identified Injury*, physicians are required to obtain pre-certification of all the services listed below. If physicians 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 associated 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. Physicians and injured parties are encouraged to maintain communication with Medlogix 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:

(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 including but not limited to the following:

1. Acupuncture;
2. Nerve blocks;
3. Manipulation under anesthesia;
4. Epidural steroid injections;
5. Radio frequency ablation/destruction by neurolytic agent/rhizotomy
6. Prescriptions, including but not limited to Schedule II, III, IV Controlled Substances, costing more than $200 for a single fill and/or a 30 day supply
7. US Food and Drug Administration (USFDA) approved narcotics, when prescribed for more than three months;
8. Pain cream and/or Compound pain medicine;
9. Biofeedback;
10. Implantation of spinal stimulator or spinal pumps;
11. Trigger point injections;
12. Non-medical products, devices, services and activities and associated suppliers, not exclusively used for medical purposes or as durable medical goods, with an aggregate cost or monthly rental in excess of $75.00;
13. Qualitative or quantitative toxicology screening;
14. Non-USFDA approved narcotics including medicinal marijuana;

(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, or rental greater than 30 days; A manufacturer's invoice is required for all durable medical equipment greater than $200;

(m) Computerized muscle testing; current perceptual testing; Temperature gradient studies, Work hardening; Carpal Tunnel Syndrome; Vax D and DRX; Podiatry; Audiology; and Bone Scans;

(n) Investigational or novel treatment as defined herein;

(o) Any and all procedures that use an unspecified CPT, CDT, DSM IV, and/or HCPC code

(p) Non-emergency transportation services

HOW TO SUBMIT DECISION POINT REVIEW/PRE-CERTIFICATION REQUESTS

Medlogix Hours of Operation – 7:00 AM to 7:00 PM EST Monday through Friday (excluding legal holidays)

In order for Medlogix to complete the review, physicians are required to submit all requests on the "Attending Physicians Treatment Plan" form. A copy of this form can be found on the DOBI website http://www.state.nj.us/dobi/pipinfo/aicrapg.htm, Medlogix's website www.medlogix.com or by contacting Medlogix at (877) 258-CERT (2378).

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

the following address: Medlogix LLC, 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619, ATTN.: Pre-Certification Department. Medlogix can be reach at (877) 258-CERT (2378).

An "Attending Physicians Treatment Plan" may not be submitted by and will not be accepted from a provider of service benefits who did not personally examine the patient. This includes, but is not limited to, DME suppliers, imaging facilities, ambulatory surgery centers, and pharmacies. The appropriate "Attending Physicians Treatment Plan" must be submitted by the attending health care provider ordering the requested treatment, diagnostic testing or durable medical equipment.

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 not notified within 3 business days, physicians may continue tests or course of treatment until such time as the final determination is communicated to them. Similarly, if an independent medical examination should be required, physicians may continue 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 Medlogix 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 Medlogix receives the submission. Medlogix 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, Medlogix's decision is due no later than close of business Monday, February 11, 2013.

POSSIBLE OUTCOMES

The following are the possible outcomes of our review:

(a) The requested service is certified.

(b) If Medlogix 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 Medlogix 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 Medlogix is unable to certify your request, the appropriate office will be notified of the results and a Medlogix Medical Director will be available through an internal reconsideration process to discuss the case with you. Medlogix 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.

(e) Authorized treatment, diagnostic testing and/or durable medical equipment is approved only for the range of dates noted in the determination. Medical authorization is based on medical necessity and is not a guarantee of payment. Medical authorization does not confirm or verify eligibility for coverage, statutory benefits, or payment.

(f) Any approved treatment, diagnostic testing and/or durable medical equipment performed/supplied after the authorization periods expires (last date in the range of dates indication in the determination) will be considered unauthorized and subject to a penalty co-payment of **50%**, even if the services are determined to be medically necessary

(g) Case Management: A Nurse Case Manager may be assigned to the claim in addition to a PIP claims representative.

INDEPENDENT MEDICAL EXAMS

If the need arises for Medlogix to utilize an independent medical exam during the decision point review/pre-certification 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.

INTERNAL APPEAL PROCESS

Prior to making a request for alternate dispute resolution, all appeals must be initiated using the forms established by the NJ Department of Banking and Insurance. The minimum required information (identified by form section number) is as follows: KEY DATES (sections 1-2) CLAIM INFO (sections 3-5) PATIENT INFO (sections 6-7 and 9-13) PROVIDER/FACILITY INFO (sections 14-25) DOCUMENTS INCLUDED INFO (section 29 indicated with asterisk) PRE-SERVICE APPEALS ISSUES INFO (sections 30-31, and 32, 33, or 34) POST-

SERVICE APPEALS ISSUES INFO (sections 30-31, 33 and/or 38 and 34-36 if completing section 38) PRE-SERVICE SIGNATURE INFO (sections 35-36) POST-SERVICE SIGNATUREE INFO (sections 39-40).

Failure to follow these requirements will be considered an incomplete submission and will result in an administrative denial. This incomplete submission does not constitute acceptance within the required timeframes for pre-service and post-service appeals.

Failure to complete the Internal Appeals procedures as outlined in 11:3-4.7B on the forms established by the Department prior to filing arbitration or litigation will invalidate any assignment of benefits.

Completion of the internal appeal process means timely submission of an appeal and receipt of the response prior to filing for alternate dispute resolution. 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.

There are two types of appeals (with specific workflows) that can be considered:

Pre-service: an appeal of the denial or modification of a decision point review or pre-certification request prior to the performance or issuance of the requested medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment on the grounds of medical necessity.

The pre-service appeal form and any supporting documentation shall be submitted by the provider to Medlogix via fax at (856) 910-2501 or in writing at 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

A pre-service appeal shall be submitted no later than **30** days after receipt of a written denial or modification of requested services.

Decisions on pre-service appeals shall be issued by the insurer or its designated vendor to the provider who submitted the appeal no later than **14** days after receipt of the pre-service appeal form and any supporting documentation. If it's determined that the new information submitted with the appeal requires the need of an expert report or an addendum to an expert report (i.e.: Peer Review, Independent Medical Exam, Medical Director Review, etc….) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

Post-service: an appeal subsequent to the performance or issuance of the services and/or what should be reimbursed.

The post-service appeal form and any supporting documentation shall be submitted by the provider to Medlogix via fax at (856) 552-1999 or in writing at 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

A post-service appeal shall be submitted at least **45** days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in Superior Court.

Decisions on post-service appeals shall be issued by the insurer or its designated vendor to the provider who submitted the appeal no later than 30 days after receipt of the appeal form and any supporting documentation. If it's determined that the new information submitted with the appeal requires the need of an expert report or an addendum to an expert report (i.e.: Professional Code Review, Medical Bill Audit

Report, UCR Analytical Analysis, etc….) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

The appeal process described above provides only one-level of appeal prior to submitting the dispute to alternate dispute resolution. 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 for that treatment.

If a claimant or provider retains counsel to represent them during the Internal Appeal Procedures, they do so strictly at their own expense. No reimbursement will be issued for counsel fees or any other costs, regardless of the outcome of the appeal.

ASSIGNMENTS OF BENEFITS

A provider, who accepts an assignment of benefits from an insured party, is 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 insurer's pre-certification plan, patient's/insured's policy, including, but not limited to, pre-certification, Decision Point Reviews, exclusions, deductibles and co- payments.

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
6. Prescription medications

When one of the above listed services, tests, prescription drugs or equipment is requested through the decision point review/pre-certification 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, prescription drugs or equipment requested. In the case of Prescription Drugs, a pharmacy card will be issued than can be presented at numerous participating pharmacies. A list of these participating pharmacies will be made available at time of card issuance.

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

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% of the eligible charge.

Coverage Restrictions

(a) The law prohibits reimbursement under any circumstances for the diagnostic testing itemized at N.J.A.C. 11:3-4.5.

(b) We will not authorize or reimburse services primarily provided for a physicians or insured parties convenience, including, but not limited to the following:

1. Investigational or novel treatment when the medical procedure, diagnostic test, durable medical equipment, drug, or other service that fails to meet any of these criteria:
    a. The technology, if any, must be approved by the appropriate federal agency
    b. There is sufficient evidence in peer-reviewed scientific literature to assess the effectiveness of the treatment.
    c. The treatment results in measureable improvement in health outcome and therapeutic benefits outweigh the risks.
    d. The treatment is as safe and effective as established standard professional treatment protocols.
    e. The treatment demonstrates effectiveness when applied outside of the investigative research setting.
    f. Prescription medications, drugs, and/or biologicals that are not approved by the USFDA
    g. Compound prescription medications, drugs, and/or biologicals that, as compound, are not approved by the USFDA. This includes, but is not limited to, compounds that may have in their formulary one or more medications, drugs, and/or biologicals individually approved by the USFDA.