

**CONCENTRA INTEGRATED SERVICES, INC.**  
**DECISION POINT REVIEW PLAN INCLUSIVE OF**  
**PRE-CERTIFICATION REQUIREMENT**

**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, *Care Paths*, for soft tissue injuries of the neck and back, collectively referred to as the *Identified Injuries*. The *Care Paths* provide that treatment be evaluated at certain intervals called *Decision Points*. On the *Care Paths*, *Decision Points* are represented by hexagonal boxes. At decision points the Named Insured, Eligible Injured Person or treating health care provider must provide us information about further treatment that is intended to be *provided (Decision Point Review)*. In addition, the administration of any diagnostic tests set forth in N.J.A.C 11:3-4.5(b) is subject to *Decision Point Review* regardless of the diagnosis. The *Care Paths* and accompanying rules, are available on the Internet on the Department's website at <http://www.nj.gov/dobi/aicrapg.htm> (Scroll down to PIP Reforms) or by calling Concentra Integrated Services, Inc. (CIS) at the telephone number designated for **Sentry Insurance A Mutual Company/Sentry Select Insurance Company, 800-818-7610**.

We will advise the *Named Insured and/or Eligible Injured Person* of the care path requirements upon notification to us of a claim filed under Personal Injury Protection. The Decision Point Review requirements do not apply to treatment or diagnostic tests administered during emergency care or during the first 10 days after the accident causing the injury.

CIS has established networks of pre-approved vendors that meet the requirements as set forth under N.J.A.C. 11:3-4.8, which can be recommended for the provision of certain services, diagnostic tests, prescription supplies, and/or durable medical equipment. *Named Insured and/or Eligible Injured Person* are encouraged, but not required, to obtain certain services, diagnostic tests, prescription supplies, and/or durable medical equipment from one of the pre-approved vendors. If they use a pre-approved vendor from one of these networks for medically necessary goods or services, they will be fully reimbursed for those goods and services consistent with the policy. If they use a vendor that is not part of these pre-approved networks, we will provide reimbursement for medically necessary goods or services but only up to seventy percent of the lesser of the following: (1) the charge or fee provided for in N.J.A.C. 11:3-29, or (2) the vendor's usual, customary and reasonable charge or fee.

We will review the course of treatment at various intervals (**Decision Points**), unless a **comprehensive treatment plan** has been precertified by us. In order for us to determine if additional treatment or the administration of a test is medically necessary, the treating provider or the *Named Insured and/or Eligible Injured Person* must provide us with reasonable prior notice together with the appropriate clinically supported findings that the anticipated treatment or test is medically necessary.

We will review this notice and supporting materials within three business days. Following our review, we have the option to:

- a. authorize reimbursement for the treatment or test; or
- b. schedule a physical examination of the ***Named Insured and/or Eligible Injured Person*** where the notice and supporting materials are insufficient to authorize or deny reimbursement for the further treatment or test.
- c. deny reimbursement for the treatment or test, where the information submitted is incomplete and/or fails to provide clinically supported findings to establish medical necessity.

If we request a physical examination:

- a. this examination will be scheduled within seven calendar days of our receipt of the notice of additional treatment or tests, unless the ***Named Insured and/or Eligible Injured Person*** agrees to extend the time period;
- b. the medical examination will be conducted by a provider in the same discipline as the treating provider;
- c. the examination will be conducted at a location reasonably convenient for the ***Named Insured and/or Eligible Injured Person***; and
- d. at our request, the treating provider or the ***Named Insured and/or Eligible Injured Person*** must provide medical records and other pertinent information to the examining provider no later than the time of the examination.
- e. when a medical examination is scheduled the ***Named Insured and/or Eligible Injured Person*** and the provider and attorney if noted, will be given notice of the examination date, time and location. The examination notice details the consequences for more than one unexcused failure to attend. If the ***Named Insured and/or Eligible Injured Person*** has two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to the ***Named Insured and/or Eligible Injured Person***, Attorney if noted and all health care providers providing treatment for the diagnosis (and related diagnosis) contained in the attending physician's treatment plan form. The notification will place the parties on notice that all future treatment, diagnostic testing, durable medical equipment or prescription drugs required for the diagnosis (and related diagnosis) contained in the attending physician's treatment plan form will not be reimbursable as a consequence for failure to comply with the plan. Treatment may proceed while the IME is being scheduled and until the results become available.

We will notify the ***Named Insured and/or Eligible Injured Person*** of our decision to authorize or deny reimbursement of the treatment or test as promptly as possible, but no later than three business days following the examination. Any denial of reimbursement for further medical treatment or tests will be based on the determination of a physician or dentist. The ***Named Insured and/or Eligible Injured Person*** or his designee may request a copy of any written report prepared in conjunction with any physical examination we request. If we fail to take any action or fail to respond to the ***Named Insured and/or Eligible Injured Person*** within three business days

after receiving the required notification and supporting medical documentation at a decision point, then the provider is permitted to continue the course of treatment until we provide the required notice.

An additional co-payment of 50 percent will apply to the eligible charge for medically necessary services, treatments and procedures, diagnostic tests, prescription supplies, durable medical equipment or otherwise potentially covered expenses that are incurred after notification to us is required for continued treatment or administration of a test if:

- a. we are not notified in accordance with the Decision Points;
- b. or provide clinically supported findings;

The examination notice details the consequences for more than one unexcused failure to attend. If the *Named Insured and/or Eligible Injured Person* has two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to the *Named Insured and/or Eligible Injured Person*, Attorney if noted and all health care providers providing treatment for the diagnosis (and related diagnosis) contained in the attending physician's treatment plan form. The notification will place the parties on notice that all future treatment, diagnostic testing, durable medical equipment or prescription drugs required for the diagnosis (and related diagnosis) contained in the attending physician's treatment plan form will not be reimbursable as a consequence for failure to comply with the plan. Treatment may proceed while the IME is being scheduled and until the results become available.

#### MANDATORY PRECERTIFICATION

If the *Named Insured and/or Eligible Injured Person* does not have an Identified Injury, we will require that the *Named Insured and/or Eligible Injured Person* or their health care provider request precertification for services, treatments and procedures outlined in Exhibit B which includes: diagnostic tests, durable medical equipment, prescription supplies, or otherwise potentially covered medical expense benefits. In the event that a *Named Insured and/or Eligible Injured Person* is injured in an automobile accident, the *Named Insured and/or Eligible Injured Person* or their health care provider should contact CIS at toll-free number **800-818-7610** in order to obtain precertification. Precertification will not apply to treatment or diagnostic tests administered during emergency care or during the first ten days after the accident causing the injury.

Our approval of requests for precertification will be based exclusively on medical necessity, as determined by using standards of good practice and standard professional treatment protocols, including, but not limited to, *Care Paths* recognized by the Commissioner of Banking and Insurance. Our final determination of the medical necessity of any disputed issues shall be made by a physician or dentist as appropriate for the injury and treatment contemplated. The *Named Insured and/or Eligible Injured Person* or their health care provider must provide us with reasonable prior notice of the anticipated services, treatments and procedures as outlined above, as well as, the appropriate clinically supported findings to facilitate timely approval. When appropriate, the health care provider may submit a **comprehensive treatment plan** for precertification.

CIS has established networks of pre-approved vendors that can be recommended for the provision of certain services, diagnostic tests, durable medical equipment and/or prescription supplies. **Named Insureds and/or Eligible Injured Persons** are encouraged, but not required, to obtain certain services, diagnostic tests, durable medical equipment and/or prescription supplies from one of the pre-approved vendors. If they use a pre-approved vendor from one of these networks for medically necessary goods or services, they will be fully reimbursed for those goods and services consistent with the policy. If they use a vendor that is not part of these pre-approved networks, we will provide reimbursement for medically necessary goods or services but only up to seventy percent of the lesser of the following: (1) the charge or fee provided for in N.J.A.C. 11:3-29, or (2) the vendor's usual, customary and reasonable charge or fee.

An additional co-payment of 50 percent will apply to the eligible charge for medically necessary services, treatments and procedures, diagnostic tests, durable medical equipment, prescription supplies, or otherwise potentially covered expenses that are incurred after notification to us is required but prior to our authorization for continued treatment or administration of a test if:

- a. we are not notified in accordance with our precertification plan,
- b. or provide clinically supported findings

This additional co-payment will not apply if we have received the required notice, supporting medical documentation, and have failed to act within three business days to authorize or deny reimbursement of further treatment or tests. Our failure to respond within three business days will allow a provider to continue treatment until we provide the required notice.

The IME requirements as outlined in Decision Point Review apply to Pre-certification.

#### **VOLUNTARY PRECERTIFICATION**

Health care providers are encouraged to participate in a voluntary precertification process by providing CIS with a **comprehensive treatment plan** for both identified and other injuries.

CIS will utilize nationally accepted criteria and the Care Paths to work with the health care provider and certify a mutually agreeable course of treatment to include itemized services and a defined treatment period.

In consideration for the health care provider's participation in the voluntary certification process, the bills that are submitted, when consistent with the precertified services, will be paid so long as they are in accordance with the PIP medical fee schedule set forth in N.J.A.C. 11:3-29.6. In addition, having an approved **comprehensive treatment plan** means that as long as treatment is consistent with the plan, additional notification to CIS is not required.

#### **DECISION POINT REVIEW PLAN PROCESS**

The requirements for precertification only apply after the tenth day following the automobile accident causing the injury. For every claim that is reported by our **Named Insured and/or**

**Eligible Injured Person**, a loss report is created and transmitted electronically to our claim office. A claim representative contacts the **Named Insured and/or Eligible Injured Person**, confirms coverage and reviews policy requirements. During this conversation, the claim representative explains that precertification is required for the services, treatments and procedures outlined in Exhibit B. Our vendor, CIS will provide assistance as the **Named Insured and /or Eligible Injured Person** proceeds through their course of treatment. The **Named Insured and/or Eligible Injured Person** is advised that they, and their provider (if known) will be contacted by CIS within 48 hours of referral to CIS to discuss their treatment plan. The **Named Insured and/or Eligible Injured Person** is provided with the toll free number to call with any questions they may have regarding the precertification process. Carrier then transfers the loss information to CIS within one business day so that they can begin the precertification process.

Within 48 hours, initial contact is made by the Nurse Case Manager at CIS with the **Named Insured and/or Eligible Injured Person** or their attorney, if represented, and the provider if known. A toll-free number, designated per **Sentry Insurance A Mutual Company/Sentry Select Insurance Company** is available. Nurse Case Managers are available 8:00 am to 5:30 pm EST Monday through Friday. The Customer Service Call Center Staff is available 24 hours a day for the **Named Insured and/or Eligible Injured Person** or attorney if represented, and their provider to call with any questions pertaining to the medical expense payment portion of the claim. During telephone consultations with a Nurse Case Manager an attempt is made by CIS to:

- Establish a detailed account of the injury without duplicating the information electronically transferred by the Carrier
- Identify medical providers currently active on the case
- Provide educational assistance in regard to the Decision Point Review Plan / Precertification

Each person will have a Nurse Case Manager assigned to their case who can answer medical or billing questions pertaining to the claim. For all other questions concerning their claim, the **Named Insured and/or Eligible Injured Person** should contact their claim representative. After this initial consultation, if the **Named Insured and/or Eligible Injured Person** or medical provider calls with a question about an existing New Jersey PIP claim as it pertains to medical expense benefits, a telephone prompt within the toll free number voicemail system **800-818-7610** offers them the option to be connected directly with the Nurse Case Manager at CIS.

During the initial telephone consultation, the **Named Insured and/or Eligible Injured Person** is also advised of **Sentry Insurance A Mutual Company's/Sentry Select Insurance Company's** designated providers for diagnostic tests; MRI, CT, CAT Scan, Somatosensory evoked potential (SSEP), visual evoked potential (VEP), brain audio evoked potential (BAEP), brain evoked potential (BEP), nerve conduction velocity (NCV), and H-reflex study, Electroencephalogram (EEG), needle electromyography (needle EMG) and durable medical equipment and prescriptions costing more than \$50.00. An exception from the network requirement applies for any of the electro diagnostic tests performed in 11:3-4.5b1-3 when done in conjunction with a needle EMG performed by the treating provider. The designated providers are approved through a Workers Compensation Managed Care Organization.

- The Atlantic Imaging Group - Diagnostic testing
- Progressive Medical – Durable Medical Equipment and Prescriptions

DIAGNOSTIC TESTING – Atlantic Imaging Group (Atlantic) is a provider based organization that arranges for the provisions of Diagnostic Radiology Services through access to a panel of preferred providers. Atlantic is a full-service management services organization that provides network access, credentialing, compliance, utilization review and quality assurance. Currently in New Jersey there are 149 participants.

DURABLE MEDICAL EQUIPMENT – Progressive Medical, Inc. offers a full service program including arrangements for fittings, delivery, set-up and training. Their national network has over 4,500 providers of which 51 are in New Jersey. The Nurse Case Manager assists in this process by obtaining a prescription from the treating provider who notes specific items needed to aid the ***Named Insured and/or Eligible Injured Person*** in recovery. The Nurse Case Manager can make referrals to the DME vendor either over the telephone or electronically via their web site. If rented, the Nurse Case Manager follows the treatment plan to determine when the ***Named Insured and/or Eligible Injured Person*** will no longer medically require the equipment. When no longer medically required, the supplying vendor will be notified to pick up the equipment.

PRESCRIPTIONS – Progressive Medical, Inc. offers multiple paths for prescription drug needs. There is access to a network of over 55,000 pharmacies nationwide of which 1,989 are in New Jersey. Their website offers a pharmacy locator service utilizing a city, state and zip code search or can also be reached via telephone. The Nurse Case Manager can make referrals to the prescription vendor either over the telephone or electronically via their web site. The eligible injured person may also call a toll free customer service help desk to find participating pharmacies in their geographic area. Mail order is also available.

PPO NETWORKS – These networks include providers in all specialties, hospitals, outpatient facilities, and urgent care centers throughout the entire State. The Nurse Case Manager can provide the ***Named Insured and/or Eligible Injured Person*** with a current PPO network list. The use of these networks is strictly voluntary and the choice of health care provider is always made by the ***Named Insured and/or Eligible Injured Person***. The PPO networks are provided as a service to those persons who do not have a preferred health care provider by giving them recommendations of providers that they may select from. Networks include CHN Solutions and Focus NJ Chiropractic PPO.

Each of the above vendors have a toll free number and web site access where they can be reached. The vendors have accessibility throughout the State. The Nurse Case Manager can provide this information as requested.

All bills for medical services will be received at the CIS office. The bills will be scanned into the document management system and entered into the Bill Review system. They will then be matched against the information entered into the system by the Nurse Case Manager and any medical necessity reviews entered by a Physician Advisor. The bills will be processed for payment if they match treatment authorized as indicated in the system. If any information differs, including diagnosis, CPT coding and services rendered, the bills will be referred to the Nurse Case

Manager for utilization review.

Any bills for services approved by utilization review will be processed for payment and returned to the Carrier for any applicable deductible and/or co-payments. A denial by a Nurse Case Manager would warrant referral to a Physician Advisor for medical necessity review. The results of the Physician Advisor's decision will be noted on the Explanation of Benefits.

### **3-Level Utilization Review Process**

1. First Level of Clinical Review - The title of the person performing first level clinical reviews is Nurse Case manager. All persons in the Nurse Case Manager position are licensed by the State of New Jersey Board of Nursing as Registered Nurses or Licensed Practical Nurses.

In the first level of review, the Nurse Case Manager will review all diagnosis codes and current procedural terminology (CPT) against the treatment and testing recommendations.

Medical documentation will be reviewed on an ongoing basis. Required medical documentation from the treating provider must include documented results of the initial and subsequent evaluations to include an assessment of any current and/or historical subjective complaints, observations, objective findings, neurologic indications, and physical tests. All previously performed tests that relate to the injury and the results must be considered in writing.

Anticipated discharge will be reviewed to verify the established treatment date. If discharge has been extended and/or an additional request for services has been made, any additional medical information needed to complete the review will be requested within two business days. If the Nurse Case Manager approves the requests, the system will be documented. Precertification authorization letters will be sent to eligible injured party/provider and attorney if noted on file the next business day. If the Nurse Case Manager cannot make this decision, the file will be routed to a Physician Advisor to review medical necessity.

When services being reviewed do not meet initial review criteria at this level, the reviewer refers it to a Physician Advisor who does a "second level" review. The Nurse Case Manager is supported by the Physician Advisor who has a non-restricted license to practice medicine in the state of New Jersey. He/She is available by telephone during normal business hours.

2. Peer Clinical Review (Second Level Review) - Second level clinical reviews are conducted only by clinical peers who hold a current non-restricted license to practice medicine in the state of New Jersey.

The Nurse Case Managers who review cases are required to refer any case that does not meet criteria to a Physician Advisor for review. The attending provider is notified of this at the time of intake. The Nurse Case Manager prints a case information sheet and gives it

to the Physician Advisor for assessment and medical determination. If additional documentation including: initial and subsequent evaluations to include an assessment of any current and/or historical subjective complaints, observations, objective findings, neurological indications, and physical tests is available, this is also submitted for review.

The Physician Advisor may:

- a. approve admission or procedure in question based on available information,
- b. consult with the attending physician to determine the need for services and/or treatment, or
- c. render an adverse decision.

Should the Physician Advisor render an adverse decision, The appropriate adverse decision notifications are processed and directed to the provider, injured party and attorney if applicable.

The Physician Advisor will complete the second level review. If he approves the request, the Utilization Review/Bill Review System will be documented and letters to the injured party/provider and attorney if applicable will be sent the next business day. If services are denied, the provider will be notified of the right to appeal the decision. A letter confirming the decision will be sent to the provider the next business day with an attachment describing the appeal process.

If a Decision Point Review request or a request to precertify any medical treatment, tests, durable medical equipment or prescriptions drugs is denied, you are entitled to seek an appeal of such decision. To access the Internal Appeals Process you must notify CIS within 30 days of the denial. A peer to peer Standard Appeal third level review will be conducted within 5-7 business days. An Expedited Appeal can be conducted within 1-3 business days. The Nurse Case Manager determines the applicable appeal process based on medical need. Appeals should be submitted to CONCENTRA INTEGRATED SERVICES, INC, P.O. Box 5038, Woodbridge, NJ 07095 or faxed to (732) 734-2587. An appeal can also be communicated to the Nurse Case Manager via telephone.

The Physician Advisor is available through CIS by telephone at the number designated for the Carrier and/or fax between 9:00 a.m. and 5:00 p.m. Eastern Standard Time every business day.

3. Peer Clinical Review: Appeals (Third Level Review) - Third level clinical reviews are conducted only by clinical peers who hold a current non-restricted license to practice medicine or a health profession in the state of New Jersey. They are Board Certified and in active practice. The provider filing an appeal only has 30 days from the date an Adverse Decision is rendered to file an appeal. If an appeal is received after 30 days it will not be considered.

Every effort will be made to select a specialist to perform the third level review that is obviously medically qualified by certification and training to deal specifically with the

clinical issue under review.

If the provider disagrees with this decision or if supporting materials are not adequate to authorize or deny further treatment or tests, an independent medical examination will be considered. Either party can appeal to an Alternate Dispute Resolution Organization as provided for in N.J.A.C. 11:3-5 if the issue can not be resolved through the Internal Appeals Process.

The claimant will be notified by telephone with confirmation in writing the next business day that a physical examination is needed. The examination will be scheduled within 7 calendar days from receipt of notice with a physician in the same area of specialty in a location reasonably convenient to the claimant. Current medical documentation, as described in the first level review process is requested and will be forwarded to the examiner for review

The *Named Insured and/or Eligible Injured Person*, provider and attorney if applicable, will be notified verbally within three business days. The results of the examination will be documented in the system. A copy of the written physical examination report will be made available upon request.

## **EXHIBIT B**

### **Services and Procedures rendered for injuries not included in the Care Paths which are subject to precertification:**

- Non-emergency inpatient and outpatient hospital care;
- Non-emergency surgical procedures;
- Extended care rehabilitation facilities;
- Outpatient care for soft-tissue/disc injuries of the person's neck, back and related structures not included within the diagnoses covered by the Care Paths;
- Physical, Occupational, speech, cognitive or other restorative therapy or other therapeutic or body-part manipulation including manipulation under anesthesia except that provided for identified injuries in accordance with decision point review;
- Outpatient psychological / psychiatric services and testing including biofeedback;
- All pain management services except as provided for identified injuries in accordance with decision point review;
- Home health care;
- Non-emergency dental restoration;
- Temporomandibular disorder; any oral facial syndrome
- Infusion therapy;
- Bone scans;
- Vax-D

- Transportation Services costing more than \$50.00;
- Brain Mapping other than provided under Decision Point Review;
- Durable Medical Equipment including orthotics and prosthetics costing more than \$50.00;
- Prescriptions costing more than \$50.00;

**INITIAL INFORMATION LETTER TO INSURED/CLAIMANT/PROVIDERS**  
**Sent on Concentra Integrated Services Letter Head**

Dear Insured and/or /Eligible Injured Person/Medical Provider:

Please read this letter carefully because it provides specific information concerning how a medical claim under Personal Injury Protection coverage will be handled, including specific requirements which you must follow in order to ensure payment for medically necessary treatment, tests, durable medical equipment and prescription drugs that a named insured or eligible injured person may incur as a result of an auto accident.

### **Decision Point Review**

The New Jersey Department of Banking and Insurance has published standard courses of treatment, *Care Paths*, for soft tissue injuries of the neck and back, collectively referred to as *Identified Injuries*. The *Care Paths* provide that treatment be evaluated at certain intervals called *Decision Points*. At decision points, either you or the treating health care provider must provide us with information about further treatment that is intended to be provided (this is referred to as *Decision Point Review*). Such information includes reasonable prior notice and the appropriate clinically supported findings that are being relied upon to support that the anticipated treatment or test is medically necessary. The Decision Point Review requirements do not apply to treatment or diagnostic tests administered during emergency care or during the first 10 days after the accident causing the injury. The *Care Paths* and accompanying rules, are available on the Internet on the Department's website at <http://www.nj.gov/dobi/aicrapg.htm> (Scroll down to PIP Reforms) or by calling CONCENTRA INTEGRATED SERVICES, INC at the number designated per **Sentry Insurance A Mutual Company/Sentry Select Insurance Company 800-818-7610**.

In addition, the administration of certain diagnostic tests is subject to *Decision Point Review* regardless of the diagnosis. The following tests are subject to decision point review:

- Needle electromyography (needle EMG)
- Somatosensory evoked potential (SSEP), visual evoked potential (VEP), brain audio evoked potential (BAEP), brain evoked potential (BEP), nerve condition velocity(NCV), and H-reflex study
- Electroencephalogram (EEG)
- Videofluoroscopy
- Magnetic resonance imaging (MRI)
- Computer assisted tomographic studies (CT, CAT scan)
- Dynatron/cyber station/cybex
- Sonograms/ultrasound
- Thermography / Thermograms
- Brain Mapping
- Any other diagnostic test that is subject to the requirements of the Decision Point Review Plan by New Jersey law or regulation.

These diagnostic tests must be administered in accordance with New Jersey Department of Banking and Insurance regulations which set forth the requirements for the use of diagnostic tests in evaluation injuries sustained in an auto accident.

We will notify you or your treating health care provider of our decision to authorize or deny reimbursement of the treatment or test as promptly as possible, but no later than three business days after a request has been made. A request for treatment, testing, durable medical equipment or prescription drugs is to be submitted together with legible, conspicuously presented, clinically supported findings that the proposed treatment, testing, durable medical equipment or prescription drugs is in accordance with the standards of medical necessity established under **Sentry Insurance A Mutual Company's/Sentry Select Insurance Company's** policy and New Jersey law. Any denial of reimbursement for further medical treatment or tests will be based on the determination of a physician or dentist. If we fail to take any action or fail to respond within three business days after receiving the required notification and supporting medical documentation at a decision point, then the treating health care provider is permitted to continue the course of treatment until we provide the required notice. Please note that the decision point review requirements do not apply to treatment or diagnostic tests administered during emergency care.

If requests for decision point reviews are not submitted or clinically supported findings that support the request are not supplied, payment of your bills will be subject to a penalty co-payment of 50 percent even if the services are determined to be medically necessary. This co-payment is in addition to any deductible or co-payment required under the Personal Injury Protection coverage.

### **Mandatory Precertification**

New Jersey regulation provides that insurers may require precertification of certain treatments or diagnostic tests for other types of injuries or tests not included in the Care Paths. Precertification means providing us with notification of intended medical procedures, treatments, diagnostic tests, prescription supplies, durable medical equipment or other potentially covered medical expenses. Precertification does not apply to treatment or diagnostic tests administered during emergency care or during the first ten days after the accident causing the injury.

The following are procedures, treatments, diagnostic tests, prescription supplies, durable medical equipment or other potentially covered medical expenses for which precertification is required:

- Non-emergency inpatient and outpatient hospital care;
- Non-emergency surgical procedures;
- Extended care rehabilitation facilities;
- Outpatient care for soft-tissue/disc injuries of the person's neck, back and related structures not included within the diagnoses covered by the Care Paths;
- Physical, Occupational, speech, cognitive or other restorative therapy or other therapeutic or body-part manipulation including manipulation under anesthesia except that provided for identified injuries in accordance with decision point review;
- Outpatient psychological / psychiatric services and testing including biofeedback;
- All pain management services except as provided for identified injuries in accordance with decision point review;
- Home health care;
- Non-emergency dental restoration;
- Temporomandibular disorder; any oral facial syndrome; Infusion therapy;

- Bone scans;
- Vax-D
- Transportation Services costing more than \$50.00;
- Brain Mapping other than provided under Decision Point Review;
- Durable Medical Equipment including orthotics and prosthetics costing more than \$50.00;
- Prescriptions costing more than \$50.00;

Our approval of requests for precertification will be based exclusively on medical necessity, as determined by using standards of good practice and standard professional treatment protocols, including, but not limited to, *Care Paths* recognized by the Commissioner of Banking and Insurance. Our final determination of the medical necessity of any disputed issues shall be made by a physician or dentist as appropriate for the injury and treatment contemplated.

If requests for precertification are not submitted or clinically supported findings that support the request are not supplied, payment of your bills will be subject to a penalty co-payment of 50 percent even if the services are determined to be medically necessary. This co-payment is in addition to any deductible or co-payment required under the Personal Injury Protection coverage.

### **Voluntary Precertification**

Health care providers are encouraged to participate in a voluntary precertification process by providing CONCENTRA INTEGRATED SERVICES, INC with a **comprehensive treatment plan** for both identified and other injuries.

CONCENTRA INTEGRATED SERVICES, INC will utilize nationally accepted criteria and the Care Paths to work with the health care provider to certify a mutually agreeable course of treatment to include itemized services and a defined treatment period.

In consideration for the health care provider's participation in the voluntary certification process, the bills that are submitted, when consistent with the precertified services, will be paid so long as they are in accordance with the PIP medical fee schedule set forth in N.J.A.C. 11:3-29.6. In addition, having an approved treatment plan means that as long as treatment is consistent with the plan, additional notification to CONCENTRA INTEGRATED SERVICES, INC at decision points is not required.

### **Voluntary Networks**

**Sentry Insurance A Mutual Company's/Sentry Select Insurance Company's** vendor, CONCENTRA INTEGRATED SERVICES, INC, has established networks of pre-approved vendors which can be recommended designated providers for diagnostic tests;; MRI, CT, CAT Scan, Somatosensory evoked potential (SSEP), visual evoked potential (VEP), brain audio evoked potential (BAEP), brain evoked potential (BEP), nerve conduction velocity (NCV), and H-reflex study, Electroencephalogram (EEG), needle electromyography (needle EMG) and durable medical equipment and prescriptions costing more than \$50.00. An exception from the network requirement applies for any of the electro diagnostic tests performed in 11:3-4.5b1-3 when done in

conjunction with a needle EMG performed by the treating provider. The designated providers are approved through a Workers Compensation Managed Care Organization

You are encouraged, but not required, to obtain the noted service from one of the pre-approved vendors. If you use a pre-approved vendor from one of these networks for medically necessary goods or services, you will be fully reimbursed for those goods and services consistent with the terms of your auto insurance policy. If you choose to use a vendor that is not part of these pre-approved networks, we will provide reimbursement for medically necessary goods or services but only up to seventy percent of the lesser of the following: (1) the charge or fee provided for in N.J.A.C. 11:3-29, or (2) the vendor's usual, customary and reasonable charge or fee. The Networks can be accessed either through a referral from the Nurse Case Manager or by contacting

The Atlantic Imaging Group - Diagnostic testing 888-340-5850

Progressive Medical – Durable Medical Equipment and Prescriptions 800-777-3574

Concentra has PPO Networks available that include providers in all specialties, hospitals, outpatient facilities, and urgent care centers throughout the entire State. The Nurse Case Manager can provide a current PPO network list. The use of these networks is strictly voluntary and the choice of health care provider is always made by the injured party. The PPO networks are provided as a service to those persons who do not have a preferred health care provider by giving them recommendations of providers that they may select from. Networks include CHN Solutions and Focus NJ Chiropractic.

### **Internal Appeals Process**

If a Decision Point Review request or a request to precertify any medical treatment, tests, durable medical equipment or prescriptions drugs is denied, you are entitled to seek an appeal of such decision. To access the Internal Appeals Process you must notify CIS within 30 days of the denial. A peer to peer Standard Appeal third level review will be conducted within 5-7 business days. An Expedited Appeal can be conducted within 1-3 business days. The Nurse Case Manager determines the applicable appeal process based on medical need. Appeals should be submitted to CONCENTRA INTEGRATED SERVICES, INC, P.O. Box 5038, Woodbridge, NJ 07095 or faxed to (732) 734-2587. An appeal can also be communicated to the Nurse Case Manager via telephone. Either party can appeal to an Alternate Dispute Resolution Organization as provided for in N.J.A.C. 11:3-5 if the issue can not be resolved through the Internal Appeals Process.

### **Assignment of Benefits**

Assignment of your rights to receive benefits for medically necessary treatment, testing, durable medical equipment or prescription drugs or other services are prohibited except to a licensed health care provider who agrees to fully comply with our Decision Point Review Plan. If the provider accepts direct payment of benefits, the provider must hold harmless the insured and/or eligible injured person for any deduction or declination in benefits caused by the provider's failure to comply with the terms of the policy and the treating provider agrees to submit disputes to Alternate Dispute Resolution Organization as provided for in N.J.A.C. 11:3-5. The assignment is limited by statute and regulation to a licensed health care provider who complies with the

restrictive language contained within the **Sentry Insurance A Mutual Company/Sentry Select Insurance Company** insurance policy.

**Medical Examinations**

At our request, we may require a medical examination (IME) to determine medical necessity of further treatment or testing. The appointment will be made within 7 calendar days of receipt of the notice that an IME is required unless the injured person agrees to extend the time period. The IME will be completed by a provider in the same discipline as the treating provider and upon request the injured person must provide medical records and other pertinent information to the provider conducting the IME. The IME will be conducted at a location reasonably convenient to the insured and/or eligible injured party. Within three business days following the examination the injured party and provider will be notified as to whether they will be reimbursed for further treatment. The injured party or his designee may request a copy of any written report prepared in conjunction with any physical examination we request. If there are two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to the Named Insured and/or Eligible Injured Person, Attorney if noted and all health care providers providing treatment for the diagnosis (and related diagnosis) contained in the attending physician's treatment plan form. The notification will place the parties on notice that all future treatment, diagnostic testing, durable medical equipment or prescription drugs required for the diagnosis (and related diagnosis) contained in the attending physician's treatment plan form will not be reimbursable as a consequence for failure to comply with the plan. Treatment may proceed while the IME is being scheduled and until the results become available.

Sincerely,

Nurse Case Managers Name  
Nurse Case Managers Telephone number with extention

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