



75 Sam Fonzo Drive · Beverly, Massachusetts 01915 · 800.227.2757 · ElectricInsurance.com

DATE

«PersonName_To»
«Address_Claimant»

RE: «PersonName_Claimant»
Claim #:«Claim Number»
DOL: «DateLoss»

«Dear»

Personal Injury Protection (PIP) is the portion of the auto policy that provides coverage for medical expenses as the result of a motor vehicle accident. These medical expenses are subject to policy limits, deductibles, co-payments and any applicable medical fee schedules. Additionally, these medical expenses must be for services that are deemed medically necessary and causally related to the motor vehicle accident. With the adoption of the Automobile Cost Reduction Act of 1998, several important changes have been made in the way a claim is processed. Additional information regarding Decision Point Review/Pre-Certification can be accessed on the Internet at the New Jersey Department of Banking and Insurance's website at <http://www.state.nj.us/dobi/pipinfo/aicrapg.htm>.

The Automobile Policy of Insurance and Electric Insurance Company®'s Decision Point Review /Pre-Certification Plan contain **VERY IMPORTANT INFORMATION ABOUT YOUR NO-FAULT COVERAGE WITH ELECTRIC INSURANCE**. You and any health care provider with whom you seek medically necessary treatment, diagnostic testing, and/or durable medical equipment are responsible for following the requirements set forth in the Automobile Policy of Insurance and Electric Insurance's Decision Point Review /Pre-Certification Plan if reimbursement for tests and treatment is sought. A portion of the relevant Decision Point Review/Pre-Certification Pan is included herein.

Consolidated Services Group, Inc. (**CSG**) has been selected by Electric Insurance as its PIP Vendor to implement their plan as required by the Automobile Cost Reduction Act. CSG will review treatment plan requests for Decision Point Review/Pre-Certification, perform Medical Bill Repricing and Audits of provider bills, coordinate Independent Medical Exams and Peer Reviews, and provide Case Management Services. A copy of informational materials approved by the New Jersey Department of Banking and Insurance is available through CSG's website at www.csg-inc.net.

The Plan Administrator of this plan is:

CSG, Inc.
300 American Metro Blvd
Suite 170
Hamilton, NJ 08619
Phone Number: 877.258.2378
Fax Number: 856.910.2501
Website www.csg-inc.net

If certain medically necessary services are performed without notifying Electric Insurance or CSG a penalty/co-payment may be applied. Medical care rendered in the first 10 days following the covered loss or any care received during an emergency situation is not subject to Decision Point Review/Pre-certification. Such treatment (within the first 10 days) shall be subject to retrospective review, as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.

Submission of Treatment Plan Requests for Decision Point Review/Pre-Certification

Your treating provider should complete the attached "Attending Provider Treatment Plan" form and forward with any applicable medical documentation to CSG by fax (856.910.2501), or mail (300 American Metro Blvd., Suite 170 Hamilton, NJ 08619 Attn: Pre-Certification Department). This form can be accessed on the DOBI website at <http://www.state.nj.us/dobi/pipinfo/aicrapg.htm> or CSG's web site at www.csg-inc.net. Any questions regarding your treatment request can be directed to CSG at 877.258.2378 during regular business hours of Monday through Friday 7:00 AM to 7:00 PM, EST except for Federally and/or State Declared Holidays and/or New Jersey declared "State of Emergencies" related to inclement weather where travel is prohibited.

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, known as Care Paths, for soft tissue injuries, collectively referred to as Identified Injuries. Additionally, guidelines for certain diagnostic tests have been established by the New Jersey Department of Banking and Insurance according to N.J.A.C. 11:3-4. *Decision Points* are intervals within the Care Paths where treatment is evaluated for a decision about the continuation or choice of further treatment the attending physician provides. At Decision Points, the eligible injured person or the health care provider must provide CSG with information regarding further treatment the health care provider intends to provide.

In accordance with N.J.A.C. 11:3-4.5, the administration of any of the following diagnostic tests is subject to Decision Point Review, regardless of diagnosis:

Diagnostic Tests, which are subject to Decision Point Review according to N.J.A.C. 11:3-4.5

1. Needle Electromyography (EMG)
2. Somatosensory Evoked Potential (SSEP)
3. Visual Evoked Potential (VEP)
4. Brain Audio Evoked Potential (BAEP)
5. Brain Evoked Potentials (BEP)
6. Nerve Conduction Velocity (NCV)
7. H-Reflex Studies
8. Electroencephalogram (EEG)
9. Videofluoroscopy
10. Magnetic Resonance Imaging (MRI)
11. Computer Assisted Tomograms (CT, CAT Scan)
12. Dynatron/Cybex Station/Cybex Studies
13. Sonogram/Ultrasound
14. Brain Mapping
15. Thermography/Thermograms

Pre-Certification

Pursuant to N.J.A.C. 11:3-4, Pre-Certification is mandatory as to any of the following medical services once 10 days have elapsed since the accident:

- Non-emergency inpatient and outpatient hospital care
- Non-emergency surgical procedures
- Infusion Therapy
- Extended Care Rehabilitation Facilities
- All 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 Path's.

- All Physical, Occupational, Speech, Cognitive, Rehabilitation or other restorative therapy or therapeutic or body part manipulation except that provided for identified injuries in accordance with decision point review.
- All Outpatient psychological/psychiatric treatment/testing and/or services

- All pain management/pain medicine services except as provided for identified injuries in accordance with decision point review
- Home Health Care
- Acupuncture
- Durable Medical Equipment (including orthotics and prosthetics), with a cost or monthly rental, in excess of \$75.00
- Non-Emergency Dental Restorations
- Temporo-mandibular disorders; any oral facial syndrome
- Current Perception Testing
- Nutritional Supplements
- All treatment and testing related to balance disorders
- Bone Scans
- Podiatry
- Any and all procedures that use an unspecified CPT/CDT, DSM IV, and/or HCPC code

Decision Point Review/Pre-Certification Process

On behalf of Electric Insurance, CSG will review all treatment plan requests and medical documentation submitted. A decision will be rendered within three business days after the receipt of a completed Attending Provider treatment Plan form request with supporting medical documentation. The Decision Point Review will be completed within 3 business days of receipt of the necessary information and notice of the decision will be communicated to the requesting medical provider by telephone and/or confirmed in writing. 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.

If additional information is requested, the decision will be rendered within three days of our receipt of the additional information. In the event that Electric Insurance or CSG does not receive sufficient medical information accompanying the request for treatment, diagnostic tests or services to make a decision, an administrative denial will be rendered, until such information is received. If a decision is not rendered within three business days of receipt of an "Attending Provider Treatment Plan" form, the treating health care provider, may render medically necessary treatment until a decision is rendered.

Failure to request decision point review or pre-certification where required, or failure to provide clinically supported findings that support the treatment, test, or durable medical equipment requested, shall result in an additional co-payment of 50% of the eligible charge for medically necessary: (1) diagnostic tests; (2) treatments; or (3) durable medical goods that were rendered/provided between the time notification to CSG was required and when CSG communicates the decision three (3) business days after the receipt of the treatment request. Such treatment shall be subject to retrospective review, as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary or reasonable.

In accordance with Order Number A16-101, all treating providers are required to submit all requests on the "Attending Provider Treatment Plan" for Decision Point Review and Precertification treatment requests. A copy of this form can be found on the NJ DOBI web site <http://www.state.nj.us/dobi/pipinfo/aicrapg.htm> or at CSG's web site www.csg-inc.net.

Providers who submit Decision Point Review/Precertification are those providers who, in part, physically and personally perform evaluations of the injured person's condition, state the specific treatment and set treatment goals. Electric Insurance will not accept Decision Point Review/Precertification requests from the following providers:

- Hospitals
- Radiologic Facilities
- Durable Medical Equipment Companies

- Ambulatory Surgery Centers
- Registered bio-analytical laboratories;
- Licensed health maintenance organizations
- Transportation Companies
- Suppliers of prescription drugs/pharmacies

If any of the above restricted providers submits a Decision Point Review/Precertification request CSG will respond to that submitting provider no later than three business days after the request informing them that they are a restricted provider and instruct them that the submission must be made by the referring/treating provider.

As it relates to this Decision Point Review Plan, the follow applies when “Days” are referenced:

- “Days” means calendar days unless specifically designated as business days.
- A calendar and business day both end at the time of the close of business hours.
- 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 days 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.

Example: Response on Decision Point Review and Precertification Requests must be communicated to the treating provider no later than three business days after the submitted request. A provider submits a proper request at Monday at 8:00 PM, which is 1 hour after the close of business hours at 7:00 PM. A response is due back to the treating provider no later than Friday at the close of the business hours.

Example: Decisions on treatment appeals shall be communicated to the provider no later than 14 calendar days from the date the insurer receives the appeal. The insurer receives the appeal by facsimile; transmission dated 3:00 P.M. on Tuesday, January 5th. Day one of the 14- calendar day period is Wednesday, January 6th. The 14th calendar day would be Tuesday, January 19th, however there is a State of Emergency Declared in New Jersey on Tuesday January 19th due to inclement weather. The insurer’s decision is due no later than Wednesday, January 20th, providing the State of Emergency has been lifted.

Decisions That May Be Communicated To You

Approved – A request for treatment/testing/Durable Medical Equipment is approved by either the Nurse or a Medical Director (if forwarded to a Medical Director Review) or as a result of an Independent Medical Examination.

Denied - A request for treatment/testing/Durable Medical Equipment is denied either by a Medical Director or an Independent Medical Examiner.

Modified- A request for treatment/testing/Durable Medical Equipment is modified either by a Medical Director or an Independent Medical Examiner.

Administrative Denial –Failure to submit “Attending Provider Treatment Plan” or an incomplete Decision Point Review and Precertification treatment request , including but not limited to an unauthorized provider, incomplete “Attending Provider Treatment Plan” and legible clinically supported record will result in the submitting provider being notified, within three business days of the incomplete submission of what is needed to complete the precertification submission Upon receipt of the required additional information, the completed request will be reviewed and a decision will be rendered three business days after the submission.

Retrospective DOS – If the request for treatment/testing/Durable Medical Equipment is for a Date of Service, which has already occurred, a decision of Retrospective DOS will be rendered.

Pended to IME: If based-on the Medical Director’s opinion a physical or mental examination is needed to render a decision, an appointment for an IME (of the same discipline and the most appropriate specialty related to the treating diagnoses) at a location reasonably convenient location to the examinee is scheduled within 7 calendar days of the date of the request. It is noted that medically necessary treatment can continue while the IME is being scheduled Such treatment shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.

Please note that the denial 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.

Voluntary Pre-Certification

We encourage you to participate in a voluntary pre-certification process by bringing a treatment plan request form to your provider or have them contact us for all services requested. CSG will utilize nationally accepted criteria to authorize a mutually agreeable course of treatment. In consideration for your participation in this voluntary pre-certification process, the bills your provider submits, when consistent with the agreed plan, will not be subject to review or audit as long as they are in accordance with the policy limits, deductibles, and any applicable PIP fee schedule. This process increases the communication between the patient, provider and CSG to develop a comprehensive treatment plan with the avoidance of unnecessary interruptions in care.

Independent Medical Examinations

CSG or Electric Insurance may request an Independent Medical Examination. At times, this examination may be necessary to reach a decision in response to the treatment plan request by the treating provider. This examination will be scheduled with a provider in the same discipline as the treating provider and the most appropriate specialty related to the treating diagnoses, as well as at a location reasonably convenient to the injured person. CSG will schedule the appointment for the examination within 7 days of the day of the receipt of the request unless the insured/designee otherwise agrees to extend the time frame. Medically necessary treatment may proceed while the examination is being scheduled and until the Independent Medical Examination results become available. Such treatment shall be subject to retrospective review, as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary. Upon completion of the Independent Medical Examination, the treating provider will be notified of the results by fax or mail within three business days after the examination. A copy of the examiner's report is available upon request. If Electric Insurance or CSG fail to respond to the request within three business days of receipt of the necessary information, the treating provider may continue the test, course of treatment, or durable medical equipment until such time as the final determination is communicated to the provider.

CSG will notify the injured party or designee and the treating provider of the scheduled physical examination and of the consequences for unexcused failure to appear at two or more appointments.

The following will constitute an unexcused failure:

1. Failure of the Injured Party to attend a scheduled IME without proper notice to CSG;
2. Failure of the Injured party to notify CSG at least two (2) days prior to the IME date;
3. Any reschedule of an unattended IME that exceeds thirty-five (35) calendar days from the date of the original IME, without permission from Electric Insurance;
4. Failure to provide requested medical records, including radiology films, at the time of the IME;
5. Failure to provide adequate proof of identification at the time of the IME; and/or
6. If the injured party that is being examined does not speak English, failure to request or provide an English speaking Interpreter for the exam.

If the injured party has two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to the injured person or their designee, and all the providers treating the injured person for the diagnosis (and related diagnoses) contained in the attending physicians treatment plan form. This 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.

Voluntary Network Services

CSG has established a network of approved vendors for diagnostic imaging studies for all MRI and CT scans, durable medical equipment with a cost or monthly rental over \$75.00, prescription drugs, and all electro diagnostic testing listed in N.J.A.C. 11:3-4.5(b) 1 through 3 except for needle EMGs, H-reflex, and nerve conduction velocity (NCV) tests performed

together by your treating provider. **Failure to use an approved vendor will result in an additional co-payment not to exceed 30 percent of the eligible charge.**

When one of the above listed services, tests 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 their designee, and the requesting provider. In addition the notice will include how to acquire a list of available preferred 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, you may visit CSG's website at www.csg-inc.net, contact CSG by phone at 877.258.2378, via fax at 856.910.2501, or in writing at 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

When you are in need of *Prescription* Drugs a pharmacy card will be issued that can be presented at numerous participating pharmacies. Instructions on how to find a list of participating pharmacies will be included with the pharmacy card.

Penalty Notification

Failure to submit requests for Decision Point Review or Pre-certification where required, or failure to submit clinically supported findings that support the treatment, diagnostic testing, or durable medical goods requested will result in a co-payment penalty of 50%. This co-payment is in addition to any co-payment stated in the insured's policy.

Assignment of Benefits

Health care providers that accept assignment for payment of benefits should be aware that they are required to hold harmless the injured person, insured or the insurance carrier for any reduction of benefits caused by the provider's failure to comply with the terms of the Decision Point Review /Pre-Certification Plan. In addition, your treating physician must agree to submit disputes to our Internal Appeals Process prior to submitting any disputes through National Arbitration Forum as per N.J.A.C. 11:3-5. **Failure to comply with the Decision Point Review /Pre-Certification Plan or the Requirements to follow the Internal Appeals Process prior to filing litigation including arbitrations will void any and all prior assignment of benefits under this policy.**

Internal Appeal Process

Appeals Regarding A Decision Related To A Treatment Request

Your treating provider may request an internal appeal on any modified or denied services or other matters related to the treatment or care of the injured person. For appeals regarding a decision related to a treatment request, notification to CSG must occur within 10 business days of the receipt of the decision in question. This appeal must be made in writing by fax or mail. This appeal must contain the treating provider's signature and the reason for the appeal. Decision Point Review /Pre-Certification Plan

Please note that any provider that has accepted an Assignment of Benefits or any insured, must comply with the Appeals Process as noted below prior to initiating arbitration or litigations, otherwise the Assignment of Benefits will be deemed null and void.

Appeals Regarding Any Issue Other Than A Decision Related To A Treatment Request

Your treating provider may request an internal appeal for any and all issues. These issues may include, but are not limited to, bill review or payment for services. This appeal must be signed by the treating provider and submitted in writing by facsimile to CSG at 856.910.2501 stating the issue being disputed along with supporting documentation. CSG's written response to this appeal will be communicated to the requesting provider by fax or mail within 14 calendar days of the receipt of the request. If your treating provider has a valid assignment of benefits, this appeal must be submitted to CSG no later than 21 calendar days prior to the initiation of any arbitration or litigation.

Please note that any provider that has accepted an assignment of benefits or any insured, must comply with the Appeals Process as noted above prior to initiating arbitration or litigations.

Non-treating providers must agree to submit appeals related to non-medical decision, including but not limited to payment issues through the internal appeals process and exhaust such appeals process prior to submitting any unresolved disputes through the current vendor approved by the NJ Department of Banking and Insurance to administer the alternative resolution (arbitration) process.

Should the assignee choose to retain an attorney to handle the Appeals Process, they do so at their own expense.

Payments/Reimbursement

Electric Insurance will reimburse all eligible medically necessary services in accordance with the most current New Jersey PIP Regulations and Fee Schedule relating to the date of service.

When provider fees are not noted in a fee schedule, Electric Insurance reserves the right to reimburse the appropriate fee schedule amount for a similar service or equipment in the region where the service or equipment was provided, or Electric Insurance will determine the reasonableness of the provider's fee by comparison of its experience with that provider and with other providers in the region. National databases of fees, such as those published by FAIR Health (www.fairhealthus.org) or Wasserman (<http://www.medfees.com/>), for example, are evidence of the reasonableness of fees for the provider's geographic region or ZIP code. The use of national databases of fees is not limited to the above examples. Electric Insurance reserves the right to reimburse whichever amount is less.

Electric Insurance has no obligation to reimburse for specific CPT/HCPC codes if approved or pre-certified in a Decision Point Review/Precertification request as it relates to applying payment methodology in the NJ PIP regulations, including but not limited to the NCCI edits. If the NCCI edits prohibit reimbursement for the codes that were billed such codes will not be reimbursed. The New Jersey Department of Banking and Insurance has adopted the NCCI edits to prevent duplication of services and unbundling of codes and the NCCI edits are part of Electric Insurance's obligation to only reimburse for medically necessary treatment. To obtain the entire current NCCI edits from the following web site: www.cms.gov/NationalCorrectCodInitEd/.

Dispute Resolution Process

If the treating provider is not satisfied with the results of CSG's Internal Appeals Process, the treating provider may file with the Dispute Resolution governed by regulations promulgated by the New Jersey Department of Banking and Insurance (N.J.A.C. 11:3-5) and can be initiated by contacting the Forthright at 732-271-6100 or toll-free at 1-888-881-6231. Information is also available on the Forthright website, <http://www.nj-no-fault.com>. Electric Insurance retains 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. Unless emergent relief is sought, failure to utilize the Appeals Process prior to filing arbitration or litigation will invalidate an assignment of benefits.

Should you have any questions or require any further information not available through the websites, do not hesitate to contact CSG or us. Electric Insurance's plan administrator, CSG, is available by phone at 877.258.2378, facsimile at 856.910.2501, or in writing at 300 American Metro Boulevard., Suite 170, Hamilton, NJ 08619.

Sincerely,

Electric Insurance Company

