

Consolidated Services Group, Inc.
3 Executive Campus, 4th Floor North
Rt. 70 & Cuthbert Boulevard
Cherry Hill, NJ 08002
Phone (856) 910-2500 Fax (856) 910-2502

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/pre-certification and medical service review of this claim for 21st Century Assurance Company, 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. 21st Century Assurance Company has 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 policyholders, injured persons and providers approved by the New Jersey Department of Banking and Insurance, is available through the Consolidated Services Group, Inc. website @ www.medlogix.com.

Please note, no decision point or pre-certification requirements shall apply within 10 days of the insured event or 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 at 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 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
- (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

In order for CSG to complete the review, you are required to submit all requests on the "Attending Physicians Treatment Plan" form in accordance with order number A04-143. A copy of this form can be found on the DOBI web site www.nj.gov/dobi/aicrapg.htm, CSG's web site www.medlogix.com or by contacting CSG at (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., 3 Executive Campus, Suite 100, Cherry Hill, NJ 08002, 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.

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 utilized before filing arbitration. If you have accepted an assignment of benefits, 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 21st Century Insurance.

Reconsideration/Appeal Process for Treatment Request Disputes

If CSG fails to certify a request for treatment, the clinical rationale for this determination is available to you upon written request. You may request the decision to be reconsidered by submitting a written request with the reason for the appeal and all supporting documentation within thirty days of receipt of the decision in question. Submission of information identical to the initial material submitted in support of the request shall not be accepted as a request for reconsideration. Provided that additional necessary medical information has been submitted, a response to the reconsideration request shall be made within fourteen days of your request in accordance with N.J.A.C. 11:3-4.7(c) 6. To notify CSG of your intention to participate in the reconsideration process, you can contact them by phone at (877) 258-CERT (2378), via fax at (856) 910-2501, or in writing at 3 Executive Campus, Suite 100, Cherry Hill, NJ 08002. This process will afford you the opportunity to discuss your appeal with a “similar discipline” Medical Director or request an independent examination scheduled by CSG.

Appeal Process for Other Disputes (any issue other than a Decision related to a Treatment Request)

You must request an internal appeal on issues not related to a request for Decision Point Review or Pre-Certification. These issues may include, but are not limited to, bill review or payment for services. Appeals must be submitted to 21st Century Insurance at least 30 days prior to the initiation of any arbitration or litigation. The appeal must be signed by the treating provider and submitted in writing stating the issue being disputed along with supporting documentation. A decision will be provided to you within thirty (30) days from receipt of the written request and all supporting documentation. Written notice of the dispute must be submitted to 21st Century Insurance at: New Jersey Appeals Administrator, 21st Century Insurance, 1000 Midlantic Drive, Suite 200, Mt. Laurel, NJ 08054. To ensure proper receipt of the dispute by us, it should be submitted via certified mail/return receipt requested through the US Postal Service or via another courier that provides proof of delivery. Proof of receipt by us must be provided at our request.

The Internal Appeal Process is an attempt to resolve disputes directly between 21st Century Insurance and the provider. Should you choose to retain an attorney to handle the Appeals Process, you do so at your own expense. No counsel fees or any other costs incurred during the Appeal process will be compensated regardless of whether the dispute is resolved on appeal or litigated.

You agree to hold harmless and indemnify 21st Century Insurance for any legal fees and/or costs awarded should you litigate any matter prior to fulfilling the Dispute Resolution requirements of the policy including utilization of the Internal Appeal Process.

PIP DISPUTE RESOLUTION PROCESS

If there is any dispute that is not resolved by the Internal Appeal Process, it may 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. 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 Reconsideration Process for disputes arising out of a request for Decision Point Review or Precertification;
- (d) agree to follow the 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 when performed

- 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 center.

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 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 at www.medlogix.com, contact CSG by phone at (877) 258-CERT (2378), via fax at (856) 910-2501, or in writing at 3 Executive Campus, Suite 100, Cherry Hill, NJ 08002.

PROVIDER REIMBURSEMENT FOR ELIGIBLE EXPENSES

You will be paid the lesser of: the amount permitted under the PPO agreement; the percent or dollar amount specified on the Medical Fee Schedules promulgated by the New Jersey Department of Banking and Insurance; or a reasonable amount, not to exceed the actual amount billed by the provider. In determining a reasonable amount, we may, as determined by us, consider third party sources of information selected by us, which may include the use of a third party health care expense database at the eightieth percentile and/or medical fee schedules for similar services or equipment in the region where the service or equipment was provided.

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

Consolidated Services Group, Inc.
3 Executive Campus, 4 North
Rt. 70 & Cuthbert Blvd.
Cherry Hill, NJ 08002

For: 21st Century Assurance Company