

##STANDARD LETTER HEAD##

User Inserts Provider Name  
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User Inserts Provider Address

RE:     ##INSURED COMPANY NAME##  
      Claim Number: ##CLAIM NUMBER##  
      Insured: ##INSURED NAME##  
      Policy Number: ##POLICY NUMBER##  
      Date of Loss: ##DATE OF LOSS##

Injured Person: ##PARTICIPANT NAME##

Dear Provider:

This letter is to advise you that Consolidated Services Group, Inc. (CSG) will administer the Decision Point Review/##QUOTE##Precertification##QUOTE##, medical service review and medical fee schedule calculations of this claim for ##INSURED COMPANY NAME##, your patient##APOSTROPHE##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. ##INSURED COMPANY NAME## has contracted with Consolidated Services Group, Inc. (the ##QUOTE##PIP Vendor##QUOTE##) for these purposes.

In accordance with N.J.A.C. 11:3-4.7(c) 3, a copy of the informational materials for policy holders, injured persons and providers approved by the New Jersey Department of Banking and Insurance, is available through the AAA Mid-Atlantic Insurance Group logo link on the Consolidated Services Group, Inc. website at [www.medlogix.com](http://www.medlogix.com).

Please note, no Decision Point Review or ##QUOTE##Precertification##QUOTE## requirement shall apply within 10 days of the insured event or to treatment administered in emergency care. This provision should not be construed so as to require reimbursement of tests and treatment that are not medically necessary.

#### **CARE PATHS/DECISION POINT REVIEW**

As mentioned above, pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance (the ##QUOTE##Department##QUOTE##) has published standard courses of treatment, **Care Paths**, for soft tissue injuries of the neck and back, collectively referred to as the ##QUOTE##Identified Injuries##QUOTE##.

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 the Decision Point Review, regardless of the diagnosis. If you fail to submit requests for the **Decision Point Review** 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##APOSTROPHE##s website at [www.nj.gov/dobi/aicrapg.htm](http://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 ##QUOTE##Precertification##QUOTE## of all the services listed below. If you fail to submit requests for the ##QUOTE##Precertification##QUOTE## 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 **QUOTE** Precertification **QUOTE** requirements may change. **QUOTE** Precertification **QUOTE** 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 **APOSTROPHE**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 the **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 the **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 **QUOTE** Attending Provider Treatment Plan **QUOTE** form in accordance with Order number A04-143. A copy of this form can be found on the DOBI web site at [www.nj.gov/dobi/aicrapg.htm](http://www.nj.gov/dobi/aicrapg.htm), CSG **APOSTROPHE**s web site at [www.medlogix.com](http://www.medlogix.com) or by contacting CSG at 1(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, phone number 1(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 the Decision Point Review and **QUOTE** Precertification **QUOTE** 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.**

## RECONSIDERATION AND APPEALS PROCESS

### Appeals Regarding a Decision related to Decision Point Review **QUOTE** Precertification **QUOTE**

You, as the treating provider, may request an internal appeal on any modified or denied service or other matters related to the treatment or care of the injured person. If CSG fails to certify a request; the clinical rationale for this determination is available to you upon written request. You can participate in CSG **APOSTROPHE**s internal review process by notifying CSG of your intention to participate in the reconsideration process, 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. In accordance with the plan, the reconsideration decision will be provided to you within fourteen (14) days of the request. 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.

### **Appeals Regarding any Issue not related to a Decision Point Review/Precertification**

For disputes on issues other than requests concerning the Decision Point Review Plan, Pre-certification, or Voluntary Networks any treating health care provider who has accepted an assignment of benefits must submit a written request for the Reconsideration and Appeals Process, specifying the issues in dispute, accompanied by supporting documentation, at least 30 days prior to filing any form of litigation or arbitration. Written notice of the dispute and request for the Reconsideration and Appeals Process shall be submitted to us via certified mail /return receipt requested or via delivery mail service providing proof of delivery. Proof of receipt by us must be provided to us upon request.

Please note that any treating health care provider who has accepted an assignment of benefits must follow the Reconsideration and Appeals Process prior to initiating arbitration or litigation.

### **DISPUTE RESOLUTION PROCESS**

Any disputes not resolved under the Decision Point Review/Precertification or the Reconsideration and Appeals Process may be submitted through the Dispute Resolution Process which is 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 National Arbitration Forum (NAF) at 1-732-271-6100 or toll-free 1-888-881-6231. Information is also available on the NAF's Web site, <http://www.nj.adrforum.com> Unless emergent relief is sought, failure to utilize the Reconsideration and Appeals Process prior to filing Arbitration or litigation will invalidate an assignment of benefits.

### **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.

## PAYMENT OF BENEFITS

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

- (a) Be subject to the requirements of our **Decision Point Review Plan, ##QUOTE##Precertification##QUOTE##**; and,
- (b) Hold the insured harmless from any reduction in benefits caused by a failure on your part to follow the **Decision Point Review Plan, ##QUOTE##Precertification##QUOTE##**; and
- (c) Submit disputes to the **##QUOTE##Reconsideration and Appeals Process##QUOTE##** prior to submitting any disputes through the Dispute Resolution Process, pursuant to N.J.A.C. 11:3-5.

All assignments are subject to all requirements, duties and conditions of the policy, including, but not limited to, the Decision Point Review Plan/##QUOTE##Pre-certification##QUOTE##, and any exclusions, deductibles or co-payments.

## VOLUNTARY NETWORKS PROGRAM

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

When one of the above listed services, tests or equipment is requested through the Decision Point Review/##QUOTE##Precertification##QUOTE## 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##APOSTROPHE##s website at [www.medlogix.com](http://www.medlogix.com) or contact CSG by phone at (877) 258-CERT (2378), fax at (856) 910-2501, or in writing at 3 Executive Campus, Suite 100, Cherry Hill, NJ 08002.

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

Sincerely,

##USER NAME##, ##USER TITLE##

Phone: ##USER PHONE##

E-Mail: ##USER EMAIL##

##FRAUD WARNING##

## APPLICATION FOR INSURER##APOSTROPHE##s CONSENT OF ASSIGNMENT OF PERSONAL INJURY PROTECTION MEDICAL EXPENSE BENEFIT PAYMENTS

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We, the undersigned Personal Injury Protection Medical Benefits injured person (Injured Person) and physician/medical provider (Provider), hereby request the Insurer##APOSTROPHE##s prior consent for the assignment of the Injured Person##APOSTROPHE##s Personal Injury Protection Medical Benefits reimbursement payments (PIP Benefits) from the Injured Person to the Provider.

**Acknowledgments:** We acknowledge that any assignment requires the prior consent of the Insurer pursuant to the terms of the private passenger automobile insurance policy under which PIP Benefits are claimed.

We acknowledge that this application in no way exercises or attempts to exercise any direction or control of the treatment of the Injured Person by the Provider and solely governs the assignment of PIP Benefits under the policy. The Provider and the Injured Person retain all rights and authority they have prior to assignment with respect to determining the treatment the Provider should render the Injured Person.

We acknowledge that the assignment of PIP Benefits does not constitute a waiver of the Insurer##APOSTROPHE##s right to contest the medical necessity of any treatment provided.

**Conditions:** We agree to follow either the Decision Point Review, ##QUOTE##Precertification##QUOTE## or any combination of these that may apply. We agree to inform the Insurer of any proposed amendment to any treatment plan prior to rendering any further treatment pursuant to the amended treatment plan. We agree to resolve any disputes relating to any of these pursuant to the ##QUOTE##Reconsideration and Appeals Process##QUOTE## and the Dispute Resolution Process as stated in the Insurer##APOSTROPHE##s policy.

Injured Person agrees to provide, upon request by the Insurer, proof of payment of co-payments and deductibles provided in the policy. Provider agrees to provide, upon request by the Insurer, adequate proof that no co-payments or deductibles have been waived or discharged.

Provider agrees to assume along with the rights of the Injured Person under the assignment of PIP Benefits, the Injured Person##APOSTROPHE##s obligation of good faith and fair dealing toward the Insurer.

**PROVIDER SIGNATURE:**

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**PROVIDER ADDRESS:**

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**INJURED PERSONS SIGNATURE:**

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**INJURED PERSONS ADDRESS:**

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**CLAIM NUMBER:**

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**DATE:**

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##FRAUD WARNING##