



00/00/00

FIRST-NAME MI LAST-NAME
BUSINESS-NAME
ST-NO STREET UNIT-NO
CITY, STATE ZIP

Insured: *INSD-FIRST-NAME INSD-MI INSD-LAST-NAME*
Claim No: *CLAIM-NO DIV-EX*
Date of Loss: *MO-LOSS/DAY-LOSS/YR*

Dear *DEAR-NAME*:

This letter is to advise you that Consolidated Services Group, Inc. (CSG) is handling decision point review/pre-certification, medical service review and medical fee schedule calculations of this claim for 21st Century Insurance, 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 Insurance has contracted with Consolidated Services Group, Inc. (the "PIP Vendor") for these purposes.

In accordance with N.J.A.C. 11:3-4.7© 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 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 @ 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 @ (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/pre-certification process, the guidelines in accordance to 11:3-4.7(e) 1-7 will be followed. This includes but is not limited to: prior notification to the injured person or his or her designee, scheduling the exam within seven calendar days of the receipt of the attending physicians treatment plan form (unless the injured person agrees to extend the time period), having the exam conducted by a provider in the same discipline, scheduling the exam at a location reasonably convenient to the injured person, and providing notification of the decision within three business days after attendance of the exam. We must be provided with all of the most recent and appropriate progress notes and the results of all tests relative to the requested services before or at the time of the scheduled examination. Failure to provide the required medical records and/or diagnostic studies/tests will be considered an unexcused failure to attend the IME.

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.

All disputes with respect to any Independent Medical Examination must be submitted to the Internal Appeal Process. If the injured person or provider retains counsel in connection with an Independent Medical Examination or submission of any matter to the Internal Appeal Process, they do so strictly at their own expense. No counsel fees or costs incurred in connection with an Independent Medical Examination or during the appeal process shall be paid or reimbursed by CSG or 21st Century Insurance.

POSSIBLE OUTCOMES

The following are the possible outcomes of our review:

- (b) The requested service is certified.
- (c) 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.
- (d) 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
- (e) 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. A provider who has taken an assignment must submit any disputes to the Internal Review Process for Reconsideration. If the provider continues to disagree with the determination following Reconsideration, the provider shall submit all disagreements to the Second Level Internal Appeal. 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.

RECONSIDERATION PROCESS

If CSG fails to certify a request, the clinical rationale for this determination is available to you upon written request. If you would like to have the decision reconsidered, you are encouraged to participate in CSG's internal review process. If you have taken on an assignment of benefits you are required to participate in this process as well as the Second Level Internal Appeal process if the dispute is not resolved in the initial internal review process. To notify CSG of your intention to participate in the reconsideration process or Second Level Appeal, you can contact them by phone @ (877) 258-CERT (2378), via fax @ (856) 910-2501, or in writing @ 3 Executive Campus, Suite 100, Cherry Hill, NJ 08002. In accordance with N.J.A.C. 11:3-4.7(c) 6 your reconsideration decision will be provided to you within fourteen (14) days of your request. 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.

The 2nd Level Internal Appeal is used, after the first level review (reconsideration) has been completed, for any unresolved dispute, including disputes related to usual and customary services/payment and for relationship of injury/treatment/testing/services to a motor vehicle accident. The "2nd Level Internal Dispute Resolution Form" can be found at www.csg-inc.net, or you may request a form by contacting: 21st Century Insurance, New Jersey PIP, 3 Beaver Valley Road, 5th Floor, Wilmington, DE 19803, phone (800) 490-1471 Ext. 22334, Fax (800) 605-5596. The Second Level Internal Appeal decision will be provided to the

assignee within thirty (30) days from receipt of the written request and all supporting documents.

ASSIGNMENTS OF BENEFITS

Please also note that, if you accept an assignment of benefits from the patient, you are required to hold the insured harmless from any reduction in benefits caused by a failure on your part to follow the decision point review/pre-certification process. In addition you agree to submit disputes to alternate dispute resolution pursuant to N.J.A.C. 11:3-5 and to Second Level Appeal before submission to Alternative Dispute Resolution. All assignments are subject to all requirements, duties and conditions of the insurer's pre-certification plan, patient's/insured's policy, including, but not limited to, pre-certification, Decision Point Reviews, exclusions, deductibles and co-payments. If you accept an assignment, you must agree to indemnify and hold us harmless for any legal fees and/or costs incurred by us as a result of your failure to utilize the Internal Appeal Process and Second Level Internal Appeal prior to the Alternate Dispute Resolution requirements of this policy. To the extent permitted by law, the results of said Alternate Dispute Resolution processes shall be final and binding, with no right of appeal. If you retain counsel to represent you during the appeal process or the Second Level Internal Appeal, you do so strictly at your own expense. No counsel fees or costs incurred during the appeal process or the Second Level Internal Appeal shall be reimbursed or paid by CSG or 21st Century Insurance.

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.

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

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

Sincerely,

ADJ-NAME

P.O. Box 52165

Phoenix, AZ 85072-2165

Toll Free: (888) 244-6163

Fax: 865-642-9237

For: 21st Century Insurance Company