<<Date>>

RE: Insured: <<Contact_FirstName>><<Contact_LastName>>
Claim Number: <<Unit_Number>>
Medlogix ID #: N/A
Date of Accident: <<Claim_LossDate>>
Claimant: <<Unit_ClaimantFirstName>><<Unit_ClaimantLastName>>

Dear Provider:

This letter is to advise you that Consolidated Services Group, Inc. (CSG) is handling decision point review/pre-certification and voluntary provider networks of this claim for <<Policy_CompanyName>>, 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. <<Policy_CompanyName>> 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.csg-inc.net/nj_auto_plans.htm.

Please note, no decision point or pre-certification requirements shall apply within 10 calendar 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.

Definitions

"Medically necessary" or **"medical necessity"** means that the medical treatment or diagnostic test is consistent with the clinically supported symptoms, diagnosis or indications of the injured person, and:
1. The treatment is the most appropriate level of service that is in accordance with the standards of good practice and standard professional treatment protocols including the Care Paths in the Appendix of NJAC 11:3-4, as applicable;
2. The treatment of the injury is not primarily for the convenience of the injured person or provider; and
3. Does not include unnecessary testing or treatment.

"Standard Professional treatment protocols" means evidence-based clinical guidelines/practice/treatment published in peer-reviewed journals.

"Utilization Management" means a system for administering some or all of an insurer's decision point review plan, including but not limited to, receiving and responding to decision point review and precertification requests, making determination of medical necessity, scheduling and performing independent medical examinations (IMEs) bill review and handling of provider appeals.

"PIP vendor" means a company used by an insurer for utilization management.

PROMPT REPORTING

We require that the Insured/Eligible Person advise and inform us about the injury and the claim as soon as possible after the accident and periodically thereafter. This may include the production of information regarding the facts of the accident, the nature and cause of the injury, the diagnosis and the anticipated course of treatment. If this information is not supplied as required, we shall impose an additional co-payment as a penalty which shall be no greater than:

a) Twenty five (25) percent when received thirty (30) or more days after the accident; or
b) Fifty (50) percent when received sixty (60) or more days after the accident.

At the request of Farmers or its vendor, a prompt report status may also occur every 60 days thereafter while the claim remains open to obtain updated information concerning the patient's medical condition.

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 legible 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 even if the services are later determined to be medically necessary. 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 legible 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 even if the services are later determined to be medically necessary. 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 calendar 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 including but not limited to the following:
1. acupuncture,
2. nerve blocks,
3. manipulation under anesthesia,
4. epidural steroid injections,
5. radio frequency/rhyzotomy,
6. narcotics, when prescribed for more than three months,
7. biofeedback,
8. implantation of spinal stimulators or spinal pumps, and
9. trigger point injections
10. non-medical products, devices, services and activities and associated supplies, not exclusively used for medical purposes or as durable medical goods, with an aggregate cost or monthly rental in excess of $75.00
(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.
(m) Computerized muscle testing; Current perceptual testing; Temperature gradient studies; Work Hardening; Carpal Tunnel Syndrome; Vax D and DRX; Podiatry; Audiology; Bone Scans
(n) Any and all procedures that use an unspecified CPT, CDT, DSM IV and/or HCPC code.

Should you require any of the following requests, please consult your claim representative to discuss the claims process for payment consideration.

1. modifications to vehicles,
2. furnishings,
3. improvements or modifications to real or personal property,
4. fixtures,
5. gym memberships.

Tests for Which the Law Prohibits Coverage under Any Circumstances

1. Spinal diagnostic ultrasound;
2. Iridology;
3. Reflexology;
4. Surrogate arm mentoring;

5. Surface electromyography (surface EMG);
6. Mandibular tracking and stimulation; and
7. Any other diagnostic test that is determined by New Jersey law or regulation to be ineligible for Personal Injury Protection coverage.

Pursuant to **N.J.A.C.** 11:3-4.5(f) and 13:30-8.22(b), we shall not provide reimbursement for the following diagnostic tests which have been identified by the New Jersey State Board of Dentistry as failing to yield data of sufficient volume to alter or influence the diagnosis or treatment plan employed to treat Temporomandibular Joint Disorder (TMJ/D):

1. Mandibular Tracking;
2. Surface EMG;
3. Sonography;
4. Doppler ultrasound;
5. Needle EMG;
6. Electroencephalogram;
7. Thermograms/thermographs;
8. Videofluoroscopy;
9. Reflexology.

Additional Requirements

Written documentation to be supplied to Farmers must be legible and clinically supported and establish that a health care provider, prior to selecting, performing or ordering the administration of a treatment, diagnostic testing or durable medical equipment, has:

1. Personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment, diagnostic testing or durable medical equipment;

2. Physically examined the patient, including making an assessment of any current and/or historical subjective complaints, observations, objective findings, neurologic indication and physical tests;

3. Considered the results of any and all previously performed tests that relate to the injury and which are relevant to the proposed treatment, diagnostic testing or durable medical equipment; and

4. Recorded and documented these observations, positive and negative findings and conclusions on the patient's medical records.

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 Provider Treatment Plan" form as adopted by the DOBI. A copy of this form can be found on the DOBI web site www.nj.gov/dobi/aicrapg.htm, CSG's web site http://www.csg- inc.net/ nj_auto_plans.htm 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., 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619,

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 fax and/or confirmed in writing. A business day is any day except Saturday, Sunday or a legal holiday between the hours of 7:00 AM EST and 7:00 PM EST. In computing any business day time period, the day from which the designated period of time begins to run shall not be included per 11:3-4.2. If you are not notified within 3 business days (as defined above), 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.

Example: Response to a properly submitted provider request is due back no later than 3 business days from the date CSG receives the submission. CSG receives an Attending Provider Treatment Plan Form by facsimile transmission dated 1:00 PM EST on Wednesday, February 6, 2013. Day one of the 3-business day period is Thursday, February 7, 2013. Since the 3rd day would be Saturday, February 9, 2013, CSG's decision is due no later than close of business, Monday, February 11, 2013.

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 provider 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.

Failure to attend the physical/mental examination request will be **excused** if the injured person notifies Farmers or CSG at least three (3) business days before the examination date of his or her inability to attend the exam. Another exam will then be scheduled to occur within the thirty-five (35) calendar days.

Failure to attend a physical/mental examination scheduled request will be **unexcused** if the injured person does not notify Farmers or CSG at least three (3) business days before the examination date of his or her inability to attend 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 providers 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 providers 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 appeal 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.

REPORTING REQUIREMENTS

For injuries *other than* the **identified injuries** outlined in the CARE PATH AND DECISION POINT and **MANDATORY PRE-CERTIFICATION SECTION ABOVE**

1. We must be provided with written support establishing the need for further treatment before reimbursement may be considered. This documentation is required if medical treatment is necessary beyond the first 30 calendar days following the accident. We encourage the submission of comprehensive treatment plans for all injuries to avoid periodic reviews when continued treatment is considered medically necessary for an extended period of time. If a comprehensive treatment plan has not been submitted and approved, notification is required every 60 calendar days following the date of the accident for as long as continued treatment is necessary if coverage is sought. As long as the treatment, diagnostic testing and/or durable medical equipment rendered/supplied is consistent with the approved treatment plan, additional notification every 60 calendar days following the accident is not required. Once a treatment plan has been approved, you or our insured must notify us in writing of the medical necessity of any treatment, diagnostic testing or durable medical equipment that varies from the approved treatment plan before reimbursement will be considered.

2. Failure to provide the notification required in paragraph one of this section, may result in a co-payment penalty on eligible medical charges of 25 percent if notice is received 30 or more calendar days after the accident or 50 percent when received 60 or more calendar days after the accident even if services are determined to be medically necessary.

INTERNAL APPEAL PROCESS

The Internal Appeal Process shall be completed before filing arbitration. If you have accepted an assignment of benefits or have a power of attorney from the insured, 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 <<Policy_CompanyName>>.

The appeal process described below provides only one-level appeal prior to submitting the dispute to alternative dispute resolution or litigation. A provider cannot submit a pre-service appeal and then a post-service appeal on the same issue. The preapproval of the treatment and the reimbursement for that treatment are separate issues. A provider can submit a pre-service appeal for the treatment and then a post-service appeal for the reimbursement of that treatment.

Completion of the internal appeal process means timely submission of an appeal and receipt of the response prior to filing for alternate dispute resolution or litigation. Except for emergency care as defined in N.J.A.C. 11:3-4.2, any treatment that is the subject of the appeal that is performed prior to the receipt by the provider of the appeal decision shall invalidate the assignment of benefits.

If you retain counsel to represent you during the Internal Appeal Process, you do so strictly at your own expense. No reimbursement will be issued for counsel fees or any costs regardless of the outcome of the appeal.

PRE-SERVICE APPEAL PROCESS

Per N.J.A.C. 11:3-4.7B, effective April 17, 2017, a pre-service appeal of a decision point review and/or precertification denial or modification must be submitted no later than thirty (30) days after receipt of a written denial or modification of requested services. If you have accepted an assignment of benefits, or have a power of attorney, you are required to participate in this process. Failure to participate timely in this process shall void the assignment of benefits and/or power of attorney.

Disputes concerning medical necessity of a denial or modification of a treatment request, are to be made as pre-service appeals. The pre-service appeals process must be completed prior to the performance or issuance of the requested service.

In accordance with N.J.A.C. 11:3-4.7B(c), appeals must be submitted on the pre-service appeal form approved by the New Jersey Department of Banking and Insurance (DOBI), available on the DOBI website: (http://www.state.nj.us/dobi/pipinfo/aicrapg.htm). The properly completed pre-service appeal form and any supporting documentation, must be submitted to CSG. In accordance with N.J.A.C.11:3-4.7B , a pre-service appeal decision will be provided to your health care provider within fourteen (14) calendar days from receipt of the properly completed pre-service appeal form and any supporting documents submitted by your health care provider or any documentation requested by us in order to complete our review. This process will afford you the opportunity to discuss the appeal with a “similar discipline” Medical Director or request an independent examination scheduled by CSG. Failure to submit a properly completed pre-service appeal form will result in an administrative denial. An incomplete submission and/or administrative denial shall not constitute acceptance within the required timeframe for pre-service appeals.

Pre-service appeals must be submitted directly to CSG, via fax at (856) 910-2501, or in writing at 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619. Pre-service appeals will only be considered valid if they are submitted to CSG at the fax number or address listed here.

POST-SERVICE APPEAL PROCESS

Effective April 17, 2017, if any payment or non-payment is unacceptable to you, the health care provider, <<Policy_CompanyName>> provides an Internal Appeal Process which is available for review of the decision to which you object. A post-service appeal must be submitted at least forty-five (45) days prior to initiating alternative dispute resolution pursuant to N.J.A.C. 11:3-5 or filing action in Superior Court.

In accordance with N.J.A.C. 11:3-4.7B(c), appeals must be submitted on the post-service appeal form approved by the New Jersey Department of Banking and Insurance (DOBI), available on the DOBI website: (http://www.state.nj.us/dobi/pipinfo/aicrapg.htm). The properly completed post-service appeal form and any supporting documentation, must be submitted to the address or fax number listed below. In accordance with N.J.A.C.11:3-4.7B , a post-service appeal decision will be provided to you within thirty (30) calendar days from receipt of the properly completed post-service appeal form and any supporting documents submitted by you or any documentation requested by us in order to complete our review. Failure to submit a properly completed post-service appeal form will result in an administrative denial. An incomplete submission and/or administrative denial shall not constitute acceptance within the required timeframe for post-service appeals.

The properly completed post-service appeal form and any supporting documentation, must be submitted to <<Policy_CompanyName>> via fax at (856) 642-9237, or via certified mail to: New Jersey Appeals Administrator, <<Policy_CompanyName>>, 1000 Midlantic Drive, Suite 200, Mt. Laurel, NJ 08054, Post service appeals will only be considered valid if they are submitted to the fax number or address listed here.

If you have accepted an assignment of benefits, or have a power of attorney, you are required to participate in this process. Failure to participate timely in this process shall void the assignment of benefits and/or power of attorney.

PIP DISPUTE RESOLUTION PROCESS

If there is any dispute (excluding coverage) that is not resolved by the Internal Appeal Process, it must 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. We retain 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. 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 Internal Appeal Process for disputes arising out of a request for Decision Point Review or Precertification;
(d) agree to follow the Internal 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 for needle EMGs, H-reflex and nerve conduction velocity (NCV) tests performed together 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.
6. Prescription drugs

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 voluntary 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 voluntary provider networks through the process outlined in the paragraph above, visit CSG's website at www.csg-inc.net/nj_auto_plans.htm, contact CSG by phone at (877) 258-CERT (2378), via fax at (856) 910-2501, or in writing at 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

PROVIDER REIMBURSEMENT FOR ELIGIBLE EXPENSES

In accordance with 11:3-29.4(a): Insurers are not required to pay for services that are not medically necessary.

You will be paid the lesser of: the amount permitted under the PPO agreement; the 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.

Consolidated Services Group, Inc.
300 American Metro Blvd.,
Suite 170
Hamilton, NJ 08619

For: <<Policy_CompanyName>>.