INITIAL INFORMATION LETTER TO INSURED/CLAIMANT/PROVIDERS Sent on Concentra Integrated Services Letter Head

Dear Insured and/or /Eligible Injured Person/Medical Provider:

Please read this letter carefully because it provides specific information concerning how a medical claim under Personal Injury Protection coverage will be handled, including specific requirements which you must follow in order to ensure payment for medically necessary treatment, tests, durable medical equipment and prescription drugs that a named insured or eligible injured person may incur as a result of an auto accident.

Decision Point Review

The New Jersey Department of Banking and Insurance has published standard courses of treatment, ***Care Paths***, for soft tissue injuries of the neck and back, collectively referred to as ***Identified Injuries***. The ***Care Paths*** provide that treatment be evaluated at certain intervals called ***Decision Points.*** At decision points, either you or the treating health care provider must provide us with information about further treatment that is intended to be provided (this is referred to as ***Decision Point Review***). Such information includes reasonable prior notice and the appropriate clinically supported findings that are being relied upon to support that the anticipated treatment or test is medically necessary. The Decision Point Review requirements do not apply to treatment or diagnostic tests administered during emergency care or during the first 10 days after the accident causing the injury. The ***Care Paths*** and accompanying rules, are available on the Internet on the Department's website at http://www.nj.gov/dobi/aicrapg.htm (Scroll down to PIP Reforms) or by calling CONCENTRA INTEGRATED SERVICES, INC at the number designated per **National General Insurance Company** www.NationalGeneral.com/claims/ReportClaim.com **.**

In addition, the administration of certain diagnostic tests is subject to ***Decision Point Review*** regardless of the diagnosis. The following tests are subject to decision point review:

- Needle electromyography (needle EMG)
- Somatosensory evoked potential (SSEP), visual evoked potential (VEP), brain audio evoked potential BAEP), brain evoked potential (BEP), nerve conduction velocity (NCV), and H-reflex study
- Electroencephalogram (EEG)
- Videofluroscopy
- Magnetic resonance imaging (MRI)
- Computer assisted tomographic studies (CT, CAT scan)
- Dynatron/cyber station/cybex
- Sonograms/ultrasound
- Thermography / Thermograms
- Brain Mapping
- Any other diagnostic test that is subject to the requirements of the Decision Point Review Plan by New Jersey law or regulation.

These diagnostic tests must be administered in accordance with New Jersey Department of Banking and Insurance regulations which set forth the requirements for the use of diagnostic tests in evaluation injuries sustained in an auto accident.

We will notify you or your treating health care provider of our decision to authorize or deny reimbursement of the treatment or test as promptly as possible, but no later than three business days after a request has been made. A request for treatment, testing, durable medical equipment or prescription drugs is to be submitted together with legible, conspicuously presented, clinically supported findings that the proposed treatment, testing, durable medical equipment or prescription drugs is in accordance with the standards of medical necessity established under **National General Insurance Company** policy and New Jersey law. Any denial of reimbursement for further medical treatment or tests will be based on the determination of a physician or dentist. If we fail to take any action or fail to respond within three business days after receiving the required notification and supporting medical documentation at a decision point, then the treating health care provider is permitted to continue the course of treatment until we provide the required notice. Please note that the decision point review requirements do not apply to treatment or diagnostic tests administered during emergency care.

If requests for decision point reviews are not submitted or clinically supported findings that support the request are not supplied, payment of your bills will be subject to a penalty co-payment of 50 percent even if the services are determined to be medically necessary. This co-payment is in addition to any deductible or co-payment required under the Personal Injury Protection coverage.

Mandatory Precertification

New Jersey regulation provides that insurers may require precertification of certain treatments or diagnostic tests for other types of injuries or tests not included in the Care Paths. Precertification means providing us with notification of intended medical procedures, treatments, diagnostic tests, prescription supplies, durable medical equipment or other potentially covered medical expenses. Precertification does not apply to treatment or diagnostic tests administered during emergency care or during the first ten days after the accident causing the injury.

The following are procedures, treatments, diagnostic tests, prescription supplies, durable medical equipment or other potentially covered medical expenses for which precertification is required:

- Non-emergency inpatient and outpatient hospital care;
- Non-emergency surgical procedures;
- Extended care rehabilitation facilities;
- 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 Paths;
- Physical, Occupational, speech, cognitivie or other restorative therapy or other therapeutic or body-part manipulation including manipulation under anesthesia except that provided for identified injuries in accordance with decision point review;
- Outpatient psychological / psychiatric services and testing including biofeedback;
- All pain management services except as provided for identified injuries in accordance with decision point review;
- Home health care;
- Non-emergency dental restoration;
- Temporomandibular disorder; any oral facial syndrome; Infusion therapy;
- Bone scans;
- Vax-D
- Transportation Services costing more than $50.00;
- Brain Mapping other than provided under Decision Point Review;
- Durable Medical Equipment including orthotics and prosthestics costing more than $50.00;
- Prescriptions costing more than $50.00;

Our approval of requests for precertification will be based exclusively on medical necessity, as determined by using standards of good practice and standard professional treatment protocols, including, but not limited to, ***Care Paths*** recognized by the Commissioner of Banking and Insurance. Our final determination of the medical necessity of any disputed issues shall be made by a physician or dentist as appropriate for the injury and treatment contemplated.

If requests for precertification are not submitted or clinically supported findings that support the request are not supplied, payment of your bills will be subject to a penalty co-payment of 50 percent even if the services are determined to be medically necessary. This co-payment is in addition to any deductible or co-payment required under the Personal Injury Protection coverage.

Voluntary Precertification

Health care providers are encouraged to participate in a voluntary precertification process by providing CONCENTRA INTEGRATED SERVICES, INC with a **comprehensive treatment plan** for both identified and other injuries.

CONCENTRA INTEGRATED SERVICES, INC will utilize nationally accepted criteria and the Care Paths to work with the health care provider to certify a mutually agreeable course of treatment to include itemized services and a defined treatment period.

In consideration for the health care provider's participation in the voluntary certification process, the bills that are submitted, when consistent with the precertified services, will be paid so long as they are in accordance with the PIP medical fee schedule set forth in N.J.A.C. 11:3-29.6. In addition, having an approved treatment plan means that as long as treatment is consistent with the plan, additional notification to CONCENTRA INTEGRATED SERVICES, INC at decision points is not required.

Voluntary Networks

National General Insurance Company's vendor, CONCENTRA INTEGRATED SERVICES, INC, has established networks of pre-approved vendors which can be recommended designated providers for diagnostic tests;; MRI, CT, CAT Scan, Somatosensory evoked potential (SSEP), visual evoked potential (VEP), brain audio evoked potential (BAEP), brain evoked potential (BEP), nerve conduction velocity (NCV), and H-reflex study, Electroencephalogram (EEG), needle electromyography (needle EMG) and durable medical equipment and prescriptions costing more than $50.00. An exception from the network requirement applies for any of the electro diagnostic tests performed in 11:3-4.5b1-3 when done in conjunction with a needle EMG performed by the treating provider. The designated providers are approved through a Workers Compensation Managed Care Organization

You are encouraged, but not required, to obtain the noted service from one of the pre-approved vendors. If you use a pre-approved vendor from one of these networks for medically necessary goods or services, you will be fully reimbursed for those goods and services consistent with the terms of your auto insurance policy. If you choose to use a vendor that is not part of these pre-approved networks, we will provide reimbursement for medically necessary goods or services but only up to seventy percent of the lesser of the following: (1) the charge or fee provided for in N.J.A.C. 11:3-29, or (2) the vendor's usual, customary and reasonable charge or fee. The Networks can be accessed either through a referral from the Nurse Case Manager or by contacting
The Atlantic Imaging Group - Diagnostic testing 888-340-5850
Progressive Medical – Durable Medical Equipment and Prescriptions 800-777-3574

Concentra has PPO Networks available that include providers in all specialties, hospitals, outpatient facilities, and urgent care centers throughout the entire State. The Nurse Case Manager can provide a current PPO network list. The use of these networks is strictly voluntary and the choice of health care provider is always made by the injured party. The PPO networks are provided as a service to those persons who do not have a preferred health care provider by giving them recommendations of providers that they may select from. Networks include CHN Solutions and Focus NJ Chiropractic.

Internal Appeals Process

If a Decision Point Review request or a request to precertify any medical treatment, tests, durable medical equipment or prescriptions drugs is denied, you are entitled to seek an appeal of such decision. To access the Internal Appeals Process you must notify CIS within 30 days of the denial. A peer to peer Standard Appeal third level review will be conducted within 5-7 business days. An Expedited Appeal can be conducted within 1-3 business days. The Nurse Case Manager determines the applicable appeal process based on medical need. Appeals should be submitted to CONCENTRA INTEGRATED SERVICES, INC, P.O. Box 5038, Woodbridge, NJ 07095 or faxed to (732) 734-2587. An appeal can also be communicated to the Nurse Case Manager via telephone. Either party can appeal to an Alternate Dispute Resolution Organization as provided for in N.J.A.C. 11:3-5 if the issue cannot be resolved through the Internal Appeals Process.

Assignment of Benefits

Assignment of your rights to receive benefits for medically necessary treatment, testing, durable medical equipment or prescription drugs or other services are prohibited except to a licensed health care provider who agrees to fully comply with our Decision Point Review Plan. If the provider accepts direct payment of benefits, the provider must hold harmless the insured and/or eligible injured person for any deduction or declination in benefits caused by the provider's failure to comply with the terms of the policy and the treating provider agrees to submit disputes to Alternate Dispute Resolution Organization as provided for in N.J.A.C. 11:3-5. The assignment is limited by statute and regulation to a licensed health care provider who complies with the restrictive language contained within the National General Insurance Company INSURANCE POLICY.

Medical Examinations

At our request, we may require a medical examination (IME) to determine medical necessity of further treatment or testing. The appointment will be made within 7 calendar days of receipt of the notice that an IME is required unless the injured person agrees to extend the time period. The
IME will be completed by a provider in the same discipline as the treating provider and upon request the injured person must provide medical records and other pertinent information to the provider conducting the IME. The IME will be conducted at a location reasonably convenient to the insured and/or eligible injured party. Within three business days following the examination the injured party and provider will be notified as to whether they will be reimbursed for further treatment. The injured party or his designee may request a copy of any written report prepared in conjunction with any physical examination we request. If there are two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to the Named Insured and/or Eligible Injured Person, Attorney if noted and all health care providers providing treatment for the diagnosis (and related diagnosis) contained in the attending physician's treatment plan form. The notification will place the parties on notice that all future treatment, diagnostic testing, durable medical equipment or prescription drugs required for the diagnosis (and related diagnosis) contained in the attending physician's treatment plan form will not be reimbursable as a consequence for failure to comply with the plan. Treatment may proceed while the IME is being scheduled and until the results become available.

Sincerely,

Nurse Case Managers Name
Nurse Case Managers Telephone number with extention