

UNITED AMERICA INSURANCE GROUP
PRE-CERTIFICATION & DECISION POINT REVIEW PROCESS

Introduction:

Throughout this document, Decision Point Review shall mean the timely review of the treatment of certain identified injuries, at the junctures in the treatment of those identified injuries, where a decision must be made about continuation or choice of further treatment. Decision Point also refers to a determination to administer one or more diagnostic tests authorized by the Department of Banking and Insurance. Our Decision Point Review Plan is more specifically described below.

Throughout this document, Care Path shall mean pre-approval of medical procedures, treatments, diagnostic tests or other services, non-medical expenses and durable medical equipment associated with injuries for which Decision Point Review shall apply. Our Pre-Certification Plan is more specifically described below.

Decision Point Review Plan:

Pursuant to the changes made as a result of the Automobile Insurance Cost Reduction Act of 1998, the New Jersey Department of Banking and Insurance has published standard courses of treatment) or Care Paths, to monitor the treatment rendered when an Eligible Injured Person ("EIP") is diagnosed with one or more of the Identified Injuries. The Care Paths provide that treatments be evaluated at certain intervals called Decision Points.

In addition, the determination to administer certain diagnostic tests also involves a Decision Point, regardless of the diagnosis. At these Decision Points, before the treatment in question is rendered, we will require the health care provider to submit documentation regarding the injuries, treatments and results of diagnostic testing. Also, we may request that a health care provider of our choice examine the EIP. The failure to request Decision Point Review when required will result in a penalty co-payment. All services must be medically necessary, clinically supported by information provided by the health care provider, and related to the injuries sustained in the accident in order to be reimbursed.

For a complete copy of the Care Paths and a list of the identified injuries, please visit the web site of the New Jersey Department of Banking and Insurance - www.nj.gov/dobil/aicrapg.htm.

The following diagnostic testing always requires a Decision Point Review as well:

Needle Electromyography (EMG);
Sonograms Evoked Potential (SSEP), Visual Evoked Potential (VEP),
Brain Audio Evoked Potential (BAEP), Brain Evoked Potential (BEP), Nerve
Conduction Velocity (NCV), or Fl.-reflex Study;
Electroencephalogram (EEG);
Videofluoroscopy;
Magnetic Resonance Imaging (*MRI*);
Computer Assisted Tomographic Studies (CT, CT Scans);
Dynatron/Cyber Station/Cybex;
Sonograms/Ultrasounds;
Thermography/Thermograms; and
Brain mapping, when done in conjunction with appropriate neurodiagnostics.

We will not pay for diagnostic testing that has no clinical value or is ineligible under the rules, regulations or laws of New Jersey, or as determined by the New Jersey Department of Banking and Insurance as being not reimbursable.

Mandatory Pre-Certification Plan:

If the EIP has been diagnosed with an injury that is not included as an Identified Injury, the health care provider must contact us for prior authorization of the treatments listed below. No pre-'certification requirements shall apply for the first ten (10) days of the insured event. Pre-Certification shall be based exclusively on medical necessity and shall not encourage under or over utilization of the treatment and test.

Any medically necessary diagnostic tests, treatments, surgery, durable medical equipment and non-medical expenses that are incurred without first complying with our Pre-Certification requirements shall be subject to a 50% co-payment.

The following require pre-certification if not authorized as part of a Comprehensive Treatment Plan approved by us:

- 1) Physical, occupational, speech, cognitive or other restorative therapy, or other body part manipulation, except that provided for identified injuries in accordance with a Decision Point Review.
- 2) Non-emergency transportation services by ambulance or ambulette~
- 3) Non-emergency surgical procedures.
- 4) Non-emergency inpatient and outpatient hospital care.
- 5) Extended care rehabilitation facilities.
- 6) Outpatient psychological, psychiatric testing and/or services.

- 7) Durable medical equipment including orthotics and prosthetics with a cost or monthly rental in excess of \$50.00,
- 8) Home health care.
- 9) All pain management services except as provided for identified injuries in accordance with Decision Point Review.
- 10) Non-emergency dental restoration.
- 11) Skilled nursing care.

General Provisions applicable to both Decision Point Review and Pre-Certification:

- 1) Any treatment to which Decision Point Review/Pre-Certification has been applied shall also be subject to all of the terms, conditions, provisions, exclusions and limitations contained within the insurance policy.
- 2) Neither Decision Point Review nor Pre-Certification will apply to the first ten (10) days of care immediately after an accident or during emergency care. Treatment received during those first ten (10) days will be subject to utilization review. This means that if treatment; testing or services received during the first ten (10) days are not appropriate and do not meet nationally recognized guidelines or protocols for such services, we may not be responsible to pay for them.
- 3) This Plan will not limit access to medically necessary care required.
- 4) This Plan will not allow for under-utilization or over-utilization of care, nor will it allow for care that is solely for the convenience of the EIP or the health care provider.
- 5) The EIP and the health care provider are strongly urged to formulate and submit a Comprehensive Treatment Plan at the beginning of treatment; regardless of whether the injury requires Decision Point Review or Pre-Certification. Once the Medical Director approves a Comprehensive Treatment Plan, there is no need to seek further approval for those services specifically described in the treatment plan.

Notification under Decision Point Review / Pre-Certification:

1. Immediately after an insured is involved in a covered accident the insured must provide notice to us of the possibility that he/she has sustained a bodily injury as a result of the motor vehicle accident. The insured MUST provide us notice, at the latest, within ten (10) days after the covered accident.

However, in the event notice is not received within 21 days of the commencement of treatment, we will reduce payments in accordance with the law or, under certain circumstances, deny the claim in accordance with NJAC 11:3-25. If notice of the accident is not received by us until 30 or more days after the accident, we reserve our right to require a co-payment of at most 25%. In the event we do not receive notice until 60 or more days after the accident, we reserve our right to require a co-payment of at most 50%.

2. The insured must provide us "with proof that the treatment he/she has already received or shall receive in the future is "clinically supported." The insured must also provide his/her treating physician's diagnosis and development of his/her treatment. Specifically the insured must provide us with:
 - a) The date of the accident;
 - b) The dates of any previous treatment;
 - c) His/her clinical symptoms;
 - d) The diagnostic tests performed and their results;
 - e) Any recommended tests; and
 - f) Any pre-existing conditions

3. Notices pursuant to the terms, conditions, provisions, exclusions and limitations of the insurance policy and this plan shall be made to:

**Active Care
119 Littleton Road
Parsippany, NJ 07054
Phone: 1-800-752-5158
Fax: 973-257-2287**

Required Information under Decision Point Review / Pre-Certification:

In order to approve treatment, we will require the health care provider to submit documentation of the nature and extent of the EIP's injuries, type and duration of treatment and diagnostic tests to be performed, and/or durable medical equipment requested. In most cases, we will be able to arrive at a decision quickly, no more than three (3) business days. However, we may need to request specific documentation to render a decision. If we do not respond to the requested treatment within three (3) business days, the EIP may proceed with treatments or tests until he/she receives notification from us that it is no longer approved.

If we make a request for additional information, the requested information needs to be submitted by the health care provider within ten (10) days and must clinically support the requested services. The failure to provide any requested medically necessary information will result in an additional penalty co-payment of 50% of eligible charges. This clinically supported information must:

- 1) Include the date of the accident;
- 2) Be based on an actual examination of the EIP, a complete history of all complaints, clinical symptoms, dates and types of previous treatments and observations;
- 3) Report objective findings, diagnoses (ICD-9 codes) and results of physical examinations and tests performed; and
- 4) Indicate that the health care provider has considered any previous tests and examinations performed, and consider any and all other conditions the EIP may have had prior to the accident, and render a diagnosis.

Bills cannot be processed for payment without supporting documentation.

It is the responsibility of the health care provider to advise us of any change in condition or need for services.

Comprehensive Treatment Plans under Decision Point Review or Pre-Certification:

The health care provider may establish, along with us, a Comprehensive Treatment Plan. This plan will be reviewed and adjusted based on information the health care provider submits and discusses with us. This Comprehensive Treatment Plan -will allow the EIP to seek needed treatment for a specific time period, which will be agreed upon by the healthcare provider and us. As the EIP's needs change, we will, along with the health care provider, change the treatment plan. Our Medical Director: will review this plan. This plan should outline treatments, diagnostic testing, special services and durable medical equipment required to recover from the injuries.

Any treatment, diagnostic tests, services or durable medical equipment that are included in an approved Comprehensive Treatment Plan are not required to be individually pre-certified. This is because the Medical Director has already reviewed the Comprehensive Treatment Plan, and the services described in the Comprehensive Treatment Plan will have been pre-approved.

If there is no Comprehensive Treatment Plan submitted, then pre-certification is required to avoid co-payment penalties.

Should there be a need, based upon the EIP's progress, to change the treatment plan, we must be advised. If the EIP is being treated pursuant to a Comprehensive Treatment Plan that has been approved by us, we will not be required to pay for any treatment that is not described in that Comprehensive Treatment Plan unless

warranted by reasons of medical necessity. A penalty of 50% of charges for unauthorized treatment may apply.

Independent Consultative Opinion Examination under Decision Point Review or Pre-Certification:

We may request that the EIP submit to an examination by a health care provider of our choosing. This examination will be with a health care provider of a similar specialty as the treating health care provider, and will take place at a location reasonably convenient to the EIP. We shall schedule this examination within seven (7) days of our request, unless the injured person agrees to extend the time period. Medically necessary treatment during this time will not be interrupted; however, it will be subject to utilization review. The EIP will be notified of our decision within three (3) days of the examination. A copy of the examining physician report is available upon request.

The EIP must cooperate with us in scheduling and attending the examination, and must provide us with all medical records and diagnostic testing results at the time of the examination. More than one unexcused failure to attend a scheduled physical examination will result in denial of reimbursement for further treatment, diagnostic testing or durable medical equipment required for the diagnosis (and related diagnosis) contained in the attending physician's treatment plan form.

Denial of any treatment, service, diagnostic testing or durable medical goods, whether under Decision Point Review or Pre-Certification, will be by a Medical Director, and will be subject to appeal. (See Internal Appeal Process). In the case of treatment prescribed by a dentist, the denial shall be by a dentist.

Penalty under Decision Point Review or Pre-Certification:

The failure to request Decision Point Review or Pre-Certification, where required or the failure to provide clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested, will result in an additional co-payment of 50% of eligible charges for medically necessary diagnostic tests, treatments or durable medical goods that were provided between the time notification to the insurer was required and the time that proper notification is made and we have an opportunity to respond in accordance with our approved Decision Point Review plan. This is in addition to any deductible or co-payment applicable to the loss.

Preferred Provider Network:

We, through our vendor, First Managed Care Options, Active Care, have contracted with Preferred Providers for the following:

- 1) Magnetic Resonance Imagery- The Active Care Network;
- 2) Computer Assisted Tomography - The Active Care Network;
- 3) The electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b) 1 through 3 except when performed by the treating physician in conjunction with a needle EMG - The Active Care Network;
- 4) Durable medical equipment with a cost or monthly rental in excess of \$ 50.00 - The Active Care Network; and
- 5) Prescription drugs - The Active Care Network.

Use of a preferred Provider is strictly voluntary. However, if you do not utilize the Preferred Provider Network for the items listed above, an additional 30% copayment will apply for each service or test Please discuss any questions regarding this with us or the Plan Administrator.

The Active Care Network, as a wholly owned subsidiary of First Managed Care Options, Inc. is approved as part of a Workers' Compensation managed care pursuant to NJAC11:6.

Per NJAC. 11:3-4.8 d) 1-2 Active Care is a proprietary health care network specializing in auto injury claims in the State of New Jersey. The Active Care Network is an auto-specific medical provider network. Participation in the network is directly related to contracts exclusively with the medical professionals, who understand the unique nature and treatment of auto related injuries.

In addition, Active Care has a PPO network available for the following services:

Medical Specialists, Chiropractors, Hospitals, and Physical and Occupational Therapy Centers.

Use of a Healthcare Provider from the PPO network is strictly voluntary and there *is* no co-pay associated with not using a PPO provider in the network. It is provided as a service to the EIP. A list can be obtained of the PPO providers in the EIP's area by contacting their case manager at Active Care directly.

Providers who participate in the Active Care PPO Network have the following five major credentialing requirements:

- 1) Active License;
- 2) Active Malpractice Insurance in the amount of 1 million liability/3 million aggregate. Malpractice cases are taken into consideration as per URAC guidelines;
- 3) Board Certification per medical specialty;
- 4) DEA certificate (Drug Enforcement Administration); and
- 5) CDS certificate (Controlled Dangerous Substance).

Credentials are updated and verified every three years as per URAC standards.

An EIP may be notified, as per their insurance policy, that a Network of Medical providers exists. Where this situation exists, Active Care telephonic nurse case managers will assist the EIP in identifying the Network providers in their area for treatment or testing purposes, as related to MVA injuries. Network participation will ensure that care is being rendered by medical professionals, who treat auto related injuries.

Upon receipt of the first report of injury and that the EIP will pursue treatment, we immediately refer the matter to our vendor, Active Care, who then sends out an Introduction letter to the EIP along with a copy of our plan. The plan identifies that the Network program is in place and the Introduction letter furnishes the EIP with contact information to obtain provider information. Active Care's telephonic nurse case manager will assist the EIP in locating a provider in their geographic area, if they choose to treat In-Network.

Internal Appeals Process:

The EIP and his/her health care provider, or someone on their behalf, may request us and the Plan Administrator to review any decision we make regarding the treatment plan, or denial of any service, treatment, diagnostic testing or durable medical goods. The Request for Appeal must be in writing and submitted to us within 14 days of our decision notification to the EIP. As part of a Request for Appeal, the EIP should provide all additional documentation he/she wishes us to consider.

We will respond to the appeal, request additional information, or request an examination with another health care provider within five (5) business days of our receipt of the appeal. If an independent consultative opinion examination is requested, it will be scheduled within seven (7) days. The decision of our Internal Appeals Committee will be forwarded to the EIP, in writing and verbally, within five (5) business days of receipt of all requested documentation.

In the event we do not resolve the dispute to the satisfaction of the EIP, the EIP may apply to the appropriate Dispute Resolution Organization as specified under the Laws and Regulations of the New Jersey Department of Banking and Insurance.

On all claims the following law applies: "Any person who knowingly and with intent to defraud any Insurance Company or other persons, files a statement of claim containing any materially, false information, or conceals for the purpose of misleading, information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and civil penalties."

Please share this document with your Health Care providers to avoid any confusion.

Assignment of Benefits

The provider must hold harmless the insured person for the penalty co-payments Imposed by the Insurer based on the provider's failure to follow the requirements of the insurer's decision point review plan. The provider must agree to submit disputes to alternate dispute resolution or the appeals process pursuant to N.J.A.C. 11:3-5.