Garden State Municipal Joint Insurance Fund (GSMJIF) and Public Entity Joint Insurance Fund (PEJIF)

DECISION POINT REVIEW PLAN

The New Jersey Department of Banking and Insurance has published standard courses of treatment, identified as Care Paths, for soft tissue injuries of the neck and back, collectively referred to as Identified Injuries, pursuant to N.J.A.C. 11:3-4. N.J.A.C. 11:3-4 also establishes guidelines for the use of certain diagnostic tests.

An Eligible Injured Person (EIP) is a person seeking Personal Injury Protection benefits (PIP) in accordance with N.J.S.A. 39:6A from an automobile insurance policy for which First Managed Care Option, Inc. is the PIP vendor, used by the Garden State Municipal Joint Insurance Fund (GSMJIF) and Public Entity Joint Insurance Fund (PEJIF) for utilization management. "Utilization Management" means a system for administering some or all decision point review plan, including, but not limited to, receiving, and responding to Decision Point Review requests, making determinations of medical necessity, scheduling and performing independent medical examinations, bill review and handling of provider appeals.

This Decision Point Review plan sets out rights and duties of persons or entities seeking PIP benefits.

Throughout this document, Decision Point Review means the timely review of 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 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 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 EIP 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. 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 Department of Banking and Insurance. www.nj.gov/dobi/aicrapg.htm.

The following diagnostic testing always requires a Decision Point Review:

1. Needle Electromyography (EMG);
2. Somasensory Evoked Potential (SSEP),
3. Visual Evoked Potential (VEP),
4. Brain Audio Evoked Potential (BAEP)
5. Brain Evoked Potential (BEP)
6. Nerve Conduction Velocity (NCV), or H-reflex Study
7. Electroencephalogram (EEG)
8. Videofluroscopy
9. Magnetic Resonance Imaging (MRI)
10. Computer Assisted Tomographic Studies (CT, CAT Scans)
11. Dynatron/Cybex Station/Cybex
12. Sonograms/Ultrasounds

13. Thermography/Thermograms
14. Brain mapping, when done in conjunction with appropriate neurodiagnostics.
15. Any other diagnostic test that is subject to the requirements of Decision Point Review by New Jersey law or regulation.

PIP benefits 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 NJ Department of Banking and Insurance as being not reimbursable.

Personal Injury protection medical expense benefits coverage shall not provide reimbursement for the following diagnostic tests, under any circumstances, pursuant to N.J.A.C. 11:3-4:

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 PIP coverage.

Decision Point Review Plan Requirements

If the EIP has been diagnosed with an injury that is not an Identified Injury, the EIP should provide prior notice of the treatments and services listed below. No prior notice requirements shall apply for the first ten (10) days of the insured event.

For treatment, diagnostic testing, durable medical equipment, or other medical expenses not included in the Care Paths or subject to Decision Point Review, the EIP is required to provide prior notice for the services and/or conditions listed below. If the EIP fails to provide prior notice (for) such services or fails to provide clinically supported findings that support the medical necessity of the treatment, services and/or conditions, diagnostic tests, other medical expenses or durable medical equipment requested, payment of bills will be subject (to) medical necessity review.

The following treatments, services and/or conditions, goods and non-medical expenses {may} require prior notice.

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. Acupuncture
3. Nerve blocks
4. Manipulation under anesthesia
5. Anesthesia when performed in conjunction with invasive techniques
6. Radiofrequency ablation/Rhyzotomy
7. Narcotics, when prescribed for more than three months
8. Biofeedback
9. Implantation of spinal simulators or spinal pumps
10. Trigger point injections
11. PENS (Percutaneous Electrical Nerve Stimulation)
12. TENS units transcutaneous electrical nerve stimulation) and supplies
13. Non-emergency transportation services by ambulance or ambulette
14. Non-emergency surgical procedures performed in a hospital, freestanding surgical center, office, etc., and any provider services associated with the surgical procedure

15. Non-emergency inpatient and outpatient hospital care including the facility where the services will be rendered, and any provider services associated with these services and/or care
16. Extended care rehabilitation facilities
17. Outpatient psychological, psychiatric testing and/or services
18. Durable medical equipment including orthotics and prosthetics with a cost or monthly rental in excess of $50.00
19. Prescriptions costing more than $50.00
20. Transportation Services costing more than $50.00
21. Home health care
22. All pain management services except as provided for identified injuries in accordance with Decision Point Review
23. Non-emergency dental restoration
24. Skilled nursing care
25. Discograms
26. Infusion therapy
27. Temperature gradient studies
28. Work hardening
29. Carpal Tunnel Syndrome
30. Audiology
31. Bone Scans
32. Non-Emergency Dental Restoration
33. Any procedure that uses an unspecified CPT, CT, DSM IV, HCPSC codes
34. Non-medical products, devices, services and activities and associated supplies, not exclusively used for medical purposes or as durable medical goods, with a cost of $50.00 and/or monthly rental greater than 30 days, including but not limited to:

    a. Vehicles
    b. Modifications to vehicles
    c. Durable goods
    d. Furnishings
    e. Improvements or modifications to real or personal property
    f. Fixtures
    g. Recreational activities and trips
    h. Leisure activities and trips
    i. Spa/gym memberships

General Provisions applicable to Decision Point Review

1. Any treatment to which Decision Point Review has been applied shall also be subject to all terms and conditions contained within the GSMJIF and PEJIF policy.
2. Neither Decision Point Review nor prior notice will apply to the first 10 days of care immediately after an accident or during emergency care. Treatment received during those first 10 days will be subject to utilization review. However, if treatment, testing or services received at any time, including the first 10 days after an accident is not medically necessary, appropriate and does not meet nationally recognized guidelines or protocols for such services, GSMJF and PEJIF may not be responsible to pay for them.
3. This Plan will not limit access to medically necessary care required. Medically necessary treatment is described as medical treatment or diagnostic test consistent with the clinically supported symptoms, diagnosis or indications of the injured persons and the treatment is the most appropriate level of service that is in accordance with standards of good practice and standard profession protocols. Standard professional treatment protocols are defined as treatment that meets evidence-based clinical guidelines/practice/treatment, published in peer-review journals.
4. This Plan will not allow for over-utilization of care, nor will it allow for the care that is solely for the convenience of the EIP or the health care provider. Pursuant to N.J.A.C. 11:3-4. 5 the plan will not allow for unnecessary testing or treatment.
5. Treatment must be Clinically Supported. Clinically supported means that a health care provider prior to

selecting, performing or ordering the administration of a treatment or diagnostic test has:

a. Personally, examined the patient to ensure that the proper medical indications exist to justify ordering the treatment or test;
b. Physically examined the patient including making an assessment of any current and /or historical subjective complaints, observations, objective findings, neurological indications, and physical tests.
c. Considered any and all previously performed tests that relate to the injury and the results and which are relevant to the proposed treatment or test; and
d. Recorded and documented these observations, positive and negative findings and conclusions on the patient's medical records.

6. First Managed Care Option, Inc. will follow procedures for the prompt review, not to exceed three business days, following our receipt of Decision Point Review/prior notice requests by a(n) EIP as established by the Department of Banking and Insurance and this Decision Point Review plan. All determinations on treatments or tests shall be based on medical necessity and shall not encourage over or under utilization of benefits. Denials of Decision Point Review and prior notice requests on the basis of medical necessity shall be based upon the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be based upon the determination of a dentist;
7. 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 prior notice. 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.

Submission Requirements under Decision Point Review

First Managed Care Option, Inc. requires the health care provider to submit documentation with 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 order to approve treatment. Upon receipt of a properly submitted prior notice treatment plan for medically necessary and clinically supported treatment, First Managed Care Option, Inc. will approve, modify or non-certify the request. First Managed Care Option, Inc. may also request additional information, if the additional information is necessary to make a decision or may request the EIP attend an Independent Medical Examination to determine medical necessity.

In order for a request to be considered and reviewed by First Managed Care Option, Inc., it must contain the following:

1. Legible, current notes from the ordering physician to support the request for treatment.
2. All supporting documentation and test results.

If we make a request for additional information, the requested information must be submitted by the health care provider within ten (10) days. The additional information must be legible and clinically support the requested services. Clinically supported information must:

1. Include the date of accident.
2. Be based on actual, current examination, a complete history of all complaints, clinical symptoms, dates and types of previous treatments and observations.
3. Report objective findings, diagnosis (ICD-10 codes) and results of physical examinations and tests performed.
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 as it relates to the accident.

All requests for Decision Point Review/prior notice must be submitted directly to First Managed Care Option, Inc. They must be submitted by fax 973-257-2287.

Garden State Municipal Joint Insurance Fund (GSMJIF) and Public Entity Joint Insurance Fund (PEJIF)

First Managed Care Option, Inc. regular business hours are 7:30 AM – 4:00 PM EST/EDT Monday – Friday. Any requests received on a weekend or legal holiday or after our regular business hours will be considered received on the next business day.

Submit a Decision Point Review/Prior Notice Request

The Attending Provider Treatment Plan (APTP) form may be completed by the healthcare provider and submitted to First Managed Care Option, Inc. for review, subject to the conditions and limitations set forth below. A health care provider is a person licensed or certified to perform health care treatment or services compensable as medical expenses in accordance with New Jersey law and regulation.

1. Physical Therapists may submit APTP forms with specific CPT codes to be used for treatment purposes; however, in order for this request to be considered complete, it must include the ordering physician's prescription, current and legible notes from the ordering physician indicating a need for physical therapy, which body part is to be treated and the response to previous treatment. A legible physical therapy evaluation must also be submitted.
2. Suppliers of Durable Medical Equipment (DME), transportation services, ambulatory surgical centers, and suppliers of prescription drugs may not submit APTP's.
3. Attending Provider Treatment Plans for diagnostic testing may only be submitted by the prescribing Health Care Provider.

It is the responsibility of the health care provider to advise First Managed Care Option, Inc. of any change in condition or need for services.

"Day or Days"

"Days" mean calendar days unless specifically designated as business days.

A calendar and business day both end at the time of the close of business hours.

In computing any period of time designated as either calendar or business days, the day from which the designated period of time begins to run shall not be included. The last day of a period of time, designated as a calendar day, is to be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday or legal holiday.

Comprehensive Treatment Plans under Decision Point Review or Prior Notice

A Comprehensive Treatment Plan may be submitted by you or your health care provider. This Comprehensive Treatment Plan will outline treatment, diagnostics, and procedures to be completed in a specified period of time. Once a Comprehensive Treatment Plan is approved or modified by a medical director, no further Decision Point Review or prior notice requests will need to be submitted unless changes need to be made.

Independent Medical Examination under Decision Point Review or Prior Notice

First Managed Care Option, Inc. or the GSMJIF and PEJIF from which PIP benefits are sought may request that the EIP submit to an Independent Medical Examination (IME). This examination will be with a health care provider in the same discipline as the treating health care provider and will take place at a location reasonably convenient to the EIP. First Managed Care Option, Inc. will schedule the examination within seven (7) days,

unless the injured person agrees to extend the time period. First Managed Care Option, Inc. will notify the EIP in writing of the appointment information. Medically necessary treatment, during this time, will not be interrupted. However, treatment will be subject to utilization review. The treating health care provider will be notified of the outcome of the exam within three (3) business days. Upon receipt of the written report from the examining physician, a letter will be sent to the EIP and treating provider with an explanation of treatment needs/denials and rationale for same.
A copy of examining physician report is available from the insurance carrier upon request.

The EIP must cooperate with us in scheduling and attending the examination.

You are required to provide the independent examining physician with all medical records and diagnostic testing including results and films at the time of the examination. Failure to provide medical records and diagnostic testing including results and films will result in an unexcused failure to attend the examination.

If you must reschedule your appointment, you must call the First MCO IME department at 973-257-5230 three business days in advance of the appointment. Failure to cancel the appointment timely will result in an unexcused failure to attend the examination. Any cancellation of appointment that is done later than 3 business days after the receipt of the appointment notice will result in and unexcused failure to attend.

If you do not speak English, you will be required to provide your own interpreter. Please have a reliable source attend the appointment with you to translate. Failure to provide translator at time of appointment will result in an unexcused failure to attend the examination.

Transportation will not be provided. Please make necessary arrangements to attend the scheduled appointment. If transportation is an issue, contact your insurance carrier to discuss any available transportation services. Failure to attend the appointment due to lack of sufficient transportation will be considered and unexcused failure to attend the examination.

There may be times when there are waits at doctors' offices. Leaving a scheduled appointment due to wait time will be considered an unexcused failure to attend the examination.

Examples of an unexcused failure to attend the examination include but are not limited to any one of the following:

1. Failure to provide medical records and diagnostic testing including results and films at the time of the examination.
2. Failure to provide adequate proof of identification.
3. Failure to be accompanied by an English-speaking translator if you do not speak English.
4. Failure to arrange for transportation.
5. Failure to cancel an examination with three business days of the exam.
6. Failure to reschedule the exam within three days of the receipt of notification of exam.
7. Failure to attend exam due to wait time.
8. Failure to present for any examination due to any reason

More than one unexcused failure to attend a scheduled physical examination may 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 due to failure to comply with the plan.

Garden State Municipal Joint Insurance Fund (GSMJIF) and Public Entity Joint Insurance Fund (PEJIF)

Preferred Provider Organization (PPO)

First Managed Care Option, Inc. also has a preferred provider organization (PPO) that includes all specialties, hospitals, outpatient and urgent care facilities. Use of the preferred provider organization is strictly voluntary. First Managed Care Option, Inc. has preferred providers through the state of New Jersey. Contact your First Managed Care Option, Inc. nurse case manager for further information regarding providers in your area.

First Managed Care Option, Inc. Appeal Process

This applies to all appeals that are submitted on or after April 17, 2017.

The Internal Appeals Process permits a health care provider who has been assigned benefits to appeal any adverse decision. An "adverse decision" is any determination by the insurer or its PIP Vendor with which the provider does not agree.

Internal appeals are divided into two types of appeals—Pre-Service Appeals and Post-Service Appeals. A completed appeal is a condition precedent to any request for alternative dispute resolution in accordance with N.J.A.C. 11:3-5. Only one-level appeal procedure is required for each issue to be appealed before making a request for alternative dispute resolution in accordance with N.J.A.C. 11:3-5 or filing an action in the Superior Court where permitted in our Decision Point Review Plan or the applicable policy of insurance.

An appeal must be in writing and submitted to First Managed Care Option, Inc. on the forms established by the New Jersey Department of Banking and Insurance (posted on the Department's website). http://www.state.nj.us/dobi/pipinfo/aicrapg.htm)

An appeal which is incomplete or illegible or fails to supply documentation and proofs to be considered, as required in this internal appeals process, will not be reviewed. The appeal shall be deemed void and a failure to comply with the terms of the First Managed Care Option, Inc. Decision Point Review Plan. An untimely filed appeal shall also be void and a failure to comply with the terms of the First Managed Care Option, Inc. Decision Point Review Plan. An assignment of benefits shall be deemed null and void as to any provider of service benefits who fails to properly file an appeal under this section.

In accordance with N.J.A.C. 11:3-7B (j), nothing herein shall be construed as to require reimbursement of services that are not medically necessary or to prevent the application of penalty copayments in N.J.S.A. 11:3-4.4 (e).

Pre-Service Appeal

Pre-Service appeals must be submitted to First Managed Care Option, Inc. via fax at 973-257-2287 or by mail to PO Box 211461 Eagan, MN 55121.
Pre-Service appeal form is located at: http://www.state.nj.us/dobi/pipinfo/preserviceappeal_170208.pdf

The health care provider may request First Managed Care Option, Inc. review any adverse decision with respect to requested treatment, diagnostic testing, other service or prescription for any medication or durable medical equipment that has not been provided. An "adverse decision" is any determination by the insurer with which the provider does not agree.

A pre-service appeal shall be submitted no later than thirty (30) days after receipt of a written modification or adverse decision as to requested treatment, diagnostic testing, other service or prescription for any medication or durable medical equipment. The appeal must indicate the issue being appealed. An appeal rationale narrative is required to be included with the form. Attached to the request, you must provide any new or additional

information or documentation you wish to be considered and upon which you do or may in the future rely upon.

A response to a complete and properly filed pre-service appeal shall be made no later than fourteen (14) days after receipt of a completed pre-service appeal form and any supporting documentation. If it is determined that an Independent Medical Examination (IME) is appropriate, this information will be communicated within 14 days.

First Managed Care Option, Inc. may request additional information or documentation. The deadline for our appeal response will pend until First Managed Care Option, Inc. receives the additional information or documentation requested.

A pre-service appeal may be submitted solely by a treating health care provider, authorized under this Decision Point Review Plan to submit Decision Point Review/Prior Notice requests.

Post-Service Appeal

Post-Service appeals must be submitted to First Managed Care Option, Inc. via fax at 973-257-2281 or by mail to PO Box 211461 Eagan, MN 55121.
Post-Service appeal form is located at:
http://www.state.nj.us/dobi/pipinfo/postserviceappeal_170208.pdf

A post-service appeal is filed subsequent to the performance or issuance of services, treatment or issuance of durable medical equipment or prescription medication. A post-service appeal shall 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 an action in the Superior Court where permitted in our Decision Point Review Plan or the applicable policy of insurance.

As a condition precedent to filing a request for alternative dispute resolution (or filing an action in the Superior Court where permitted in our Decision Point Review Plan or the applicable policy of insurance), a provider of service benefits who has accepted an assignment and has received an adverse decision subsequent to the performance or issuance of services, or an adverse decision as to what the insurer should reimburse the provider for such performance or issuance of services (other than a medical procedure, treatment, diagnostic test, other service and/or durable medical equipment for which a pre-service appeal on the grounds of medical necessity is required) must submit an appeal as to all disputes.

Attached to the request, you must provide any information or documentation you wish to be considered and upon which you do or may in the future rely upon in support of the objection to any adverse decision. The appeal must specify specifically the issue being appealed. The appeal must include all information and documentation as to all proofs upon which the party filing the appeal does or may rely. An appeal rationale narrative is required to be included with the form.

Appeals regarding a dispute as to the usual, customary and reasonable reimbursement for services shall include documentation upon which the provider intends to rely to establish it's usual, customary and reasonable fees received from all payors. Appeals regarding any dispute as to any PPO agreement must provide all information and documentation which the health care provider intends to prove or rebut the application of the PPO agreement and/or the rates paid or payable under such agreement. Appeals regarding a dispute as to Health Care Primary coverage must also include all Explanation of Benefits forms received by the provider and/or patient from the Health Care Insurer.

Our decision will be issued no later than thirty (30) days after receipt of a properly filed post-service appeal form and supporting documentation.

First Managed Care Option, Inc. may request additional information or documentation. The deadline for our appeal response will pend until First Managed Care Option, Inc. receives the additional information or documentation requested.