

## Decision Point Review/Pre-Certification Notice

Lincoln General Insurance Company has designated United Review Services as the vendor responsible for administering Decision Point Review and Pre-certification services for auto no-fault claims under policies issued by the company. This notice contains important information for you and your treating provider regarding how your claim will be handled and the Decision Point Review and Pre-certification requirements which you and your treating provider must follow in order to receive maximum benefits provided by your policy. These Decision Point Review and Pre-certification requirements are mandated under applicable New Jersey regulations. A copy of this Notice is also available on our web site at <http://www.lincolngeneral.com/>.

Please note that no Decision Point Review or Pre-certification requirements shall apply within ten (10) days of the insured event or to treatment administered in emergency care. However, this should not be construed so as to require reimbursement of tests and treatment that are not medically necessary. N.J.A.C. 11:3-4.7 (b)

### Decision Point Review:

Pursuant to N.J.A.C. 11:3-4, 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, referred to herein as the **Identified Injuries**. For a list of these injuries, see **Exhibit A**. The Care Paths require that treatment for identified injuries be evaluated at certain intervals called **Decision Points**. At these Decision Points, the injured person and/or medical providers must provide information about further treatment that is intended to be provided, so that URS can perform a **Decision Point Review**. In addition, any diagnostic test set forth in N.J.A.C. 11:3-4.5 (b) is subject to Decision Point Review regardless of the diagnosis. (See **Exhibit B**). If you or your providers fail to submit requests for Decision Point Review as required, or fail to provide clinically supported findings that support the request, payment of your bills will be subject to a co-payment penalty of 50%, even if the services are determined to be medically necessary. The Care Paths and accompanying rules are available on the Internet on the Department's website [www.state.nj.gov/dobi/aicrapg.htm](http://www.state.nj.gov/dobi/aicrapg.htm) or available by calling URS at 800-546-2774.

### **Mandatory Pre-certification:**

For treatment of injuries other than an Identified Injury, you or your providers are required to obtain Pre-certification from URS for all of the services listed below. If you or your providers fail to submit requests for Pre-certification as required, or fail to provide clinically supported findings that support the treatment, diagnostic tests or DME requested, payment of bills will be subject to a penalty co-payment of 50% even if the services are determined to be medically necessary. The following treatments, services, goods and non-medical expenses require Pre-certification, unless they are part of a previously approved treatment plan.

- Non-Emergency Inpatient and Outpatient Hospital Care
- All Non-Emergency Psychological/Psychiatric Services
- Extended Care and Rehabilitation Facilities
- All Home Health Care
- Non-Emergency Dental Restoration
- Durable Medical Goods, including orthotics and prosthetics, that collectively exceed \$50.00 rental over 30 days.
- Physical, Occupational, Speech, Cognitive, or other restorative therapy or Body part manipulation, including massage therapy, except that provided for Identified Injuries in accordance with Decision Point Review.
- All Pain Management services, except as provided for Identified Injuries in accordance with Decision Point Review.
- Infusion Therapy
- Temporomandibular Disorders
- Bone Scans
- Vax-D

### **How to Submit Decision Point Review and Pre-certification Requests:**

The health care provider is required to submit all requests on the Attending Provider Treatment Plan form. A copy of this form can be found on the DOBI web site [www.nj.gov/dobi/aicrapg.htm](http://www.nj.gov/dobi/aicrapg.htm), or by contacting URS at 800-546-2774.

The health care provider should submit the completed form, along with a copy of their most recent/appropriate progress notes and the results of any tests relative to the requested services to URS via fax at 732-382-1125 or mail to the following address:

United Review Services, Attn: Precert Department  
10 Corporate Place, Suite 206  
Piscataway, NJ 08854

You or your provider may also call URS with questions concerning your medical treatment, the Decision Point Review Process, or Pre-certification procedures at: 800-546-2774.

- 2 -

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 both you and your health care provider by telephone, fax and/or confirmed in writing. If your health care provider is not notified within 3 business days, they may continue your test or course of treatment until such time as the final determination is communicated to them. If an independent medical examination should be required, they may continue your tests or course of treatment until the results of the examination become available. Based upon the information and documentation received, requested treatment may be either:

1. Certified (approved) if criteria are met.
2. Non-certified due to insufficient medical documentation to conduct review.
3. Certified on a modified basis, authorizing the portion of the medical treatment which meets criteria and non-certifying the portion of treatment determined not to meet medical necessity criteria.
4. Non-certified due to failure of the requested treatment to meet the criteria for medical necessity according to the Care Paths or national criteria.

**Any denials of treatment on the basis of medical necessity shall be by the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist.**

If we are unable to determine the medical necessity of further treatment, testing or durable medical equipment you may be required to attend an Independent Medical Examination (IME) at Lincoln General Insurance Company's expense. The IME will be scheduled within 7 calendar days of receipt of the Attending Provider Treatment Request Plan form unless you agree to extend the time period.

The Independent Medical Examination will be conducted by a health care provider within the same specialty of your treating health care provider and will be conducted in a location convenient to you. The results of the IME and the determination regarding your Decision Point Review or Pre-certification request will be submitted to you in writing and to your health care provider in writing and by telephone within 3 business days after the examination. Please note that your medically necessary treatment may proceed while the Independent Medical Examination is being scheduled and until the results are available. The examining provider will prepare a written report of the results of the examination, and you or your designee shall be entitled to a copy of the report upon request.

You are required to provide all medical records and diagnostic studies/tests available 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 you have two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to you, and all health care providers treating you for the diagnosis (and related diagnoses) contained in the Attending Provider Treatment Plan form. The notification will place you on notice that all future treatment, diagnostic testing or durable medical equipment required for the diagnosis (and related diagnosis) contained in the Attending Provider Treatment Plan form will not be reimbursable as a consequence for failure to comply with the plan.

**Voluntary Provider Networks: Utilization Program:**

In accordance with the regulations, 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 when performed by the treating physician and the electro-diagnostic tests performed by the treating physician in conjunction with a needle EMG.

When one of the above listed services is requested through the Decision Point Review/Pre-certification process, a letter containing the outcome of the review is sent to you, and the requesting health care provider. The notice will include a list of available preferred provider networks, with phone numbers and addresses, to obtain the medically necessary services requested. The use of these networks will allow your benefit dollars to go further. 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% of the eligible charge.

**Penalties:**

As outlined in N.J.A.C. 11:3-4.4 3 (d); Failure to request Decision Point Review or Pre-certification where required or failure to provide clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested shall result in an additional co-payment of 50% of the eligible charge for medically necessary diagnostic tests or treatments that were provided between the time notification to the Company was required and the time that the proper notification is made and the Company has an opportunity to respond in accordance with its approved Decision Point Review/Pre-certification plan.

**Assignment of Benefits:**

At Lincoln General Insurance Company's option, medical expense benefits may be paid to you or to your health care provider. These benefits shall not be assignable except to providers of service benefits. Any attempt to assign benefits to a party who is not a provider of service benefits shall be null and void and shall not be honored. If so assigned, all requirements and duties of cooperation following an accident or loss shall remain in effect. If a valid assignment is made by you and accepted by your provider of the assigned service benefits, your provider shall indemnify and hold you harmless for any deduction or declination in benefits caused by your provider's failure to comply with the terms of this Plan. In addition, your provider must agree to submit disputes to alternate dispute resolution in accordance with N.J.A.C. 11:3-5.

**Appeal Process:**

The claimant, his designee or health care provider may request URS to review any decision we make regarding your treatment plan, or denial of any service, treatment, diagnostic test, or durable medical goods. The Request for Appeal must be in writing and submitted to us within 30 days of the adverse determination. Attached to the request, the claimant or provider must provide any additional documentation they wish us to consider. If the information submitted with the appeal is insufficient for URS to render a determination, URS will respond to the appeal by requesting additional information, or request an examination with another health care provider. The decision of our Internal Appeals Committee will be forwarded in writing to you within 14 business days of receipt of all documentation required. If resolution of your request requires immediate attention, we will forward our decision within three (3) business days. The Medical Director is available to discuss the appeal with the treating provider.

In the event we do not resolve the dispute, you may apply to the appropriate Dispute Resolution Organization as specified under the Laws and Regulations promulgated by the Department of Insurance and Banking.

## **EXHIBIT A**

# **Identified Injuries**

**The following diagnoses are subject to the New Jersey Care Paths and the Decision Point Review Process:**

### **ICD-9 Codes**

- 722.0 Displacement of cervical intervertebral disc without myelopathy
- 722.1 Displacement of thoracic or lumbar intervertebral disc without myelopathy
- 722.10 Displacement of lumbar intervertebral disc without myelopathy
- 722.11.1 Displacement of thoracic intervertebral disc without myelopathy
- 722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
- 722.70 Intervertebral disc disorder with myelopathy, unspecified region
- 722.71 Intervertebral disc disorder with myelopathy, cervical region
- 722.72 Intervertebral disc disorder with myelopathy, thoracic region
- 722.73 Intervertebral disc disorder with myelopathy, lumbar region
- 728.0 Disorders of muscle, ligament and fascia
- 728.85 Spasm of muscle
- 739.0 Non-allopathic lesions - not elsewhere classified
- 739.1.1.1 Somatic dysfunction of cervical region
- 739.1.1.2 Somatic dysfunction of thoracic region
- 739.3 Somatic dysfunction of lumbar region
- 739.4 Somatic dysfunction of sacral region
- 739.8 Somatic dysfunction of rib cage
- 846.0 Sprains and strains of sacroiliac region
- 846.1 Sprains and strains of lumbosacral (joint) (ligament)
- 846.2 Sprains and strains of sacrospinatus (ligament)
- 846.3 Sprains and strains of sacrotuberous region
- 846.8 Sprains and strains of other specified sites of the sacroiliac region
- 846.9 Sprains and strains of unspecified site of sacroiliac region
- 847.0 Sprains and strains of neck
- 847.1 Sprains and strains, thoracic
- 847.2 Sprains and strains, lumbar
- 847.3 Sprains and strains, sacrum
- 847.4 Sprains and strains, coccyx
- 847.9 Sprains and strains of back, unspecified site
- 922.3 Contusion of back
- 922.31 Contusion of back, excludes interscapular region
- 922.33 Contusion of back, interscapular region
- 953.0 Injury to cervical root
- 953.2 Injury to lumbar root
- 953.3 Injury to sacral root

## **EXHIBIT B**

### **Diagnostic Testing for Decision Point Review**

The following diagnostic tests are subject to Decision Point Review regardless of diagnosis:

- Brain Mapping
- Brain Audio Evoked Potentials (BAEP)
- Brain Evoked Potentials (BEP)
- Computer Assisted Tomograms (CT, CAT Scan)
- Dynatron/cybex station/cybex studies
- Videofluoroscopy
- H-Reflex Studies
- Sonogram/Ultrasound
- Needle Electromyography
- Nerve Conduction Velocity (NCV)
- Somatosensory Evoked Potential (SSEP)
- Magnetic Resonance Imaging (MRI)
- Electroencephalogram (EEG)
- Visual Evoked Potential (VEP)
- Thermogram/Thermography
- Any other diagnostic test that is subject to the requirements of Decision Point Review by New Jersey law or regulation

## **Voluntary Networks**

### **Voluntary Provider Networks: Utilization Program:**

In accordance with the regulations, 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 when performed by the treating physician and the electro-diagnostic tests performed by the treating physician in conjunction with a needle EMG.

When one of the above listed services, tests or equipment is requested through the Decision Point Review/Pre-certification process, a letter containing the outcome of the review is sent to you, and the requesting health care provider. The notice will include a list of available preferred provider networks, with phone numbers and addresses, to obtain the medically necessary services or tests requested. The use of these networks will allow your benefit dollars to go further. 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% of the eligible charge.

### **Voluntary Networks:**

United Review Services will use the following Voluntary Networks in accordance with the N.J.A.C. 11:3-4.8 regulations. These networks will provide quality service and locations throughout all counties in New Jersey.

The following network is currently being utilized by United Review Services:

MRI and CAT Scan Imaging and Electro-diagnostic Testing Vendor: Raytel Imaging Network offers over 120 fully licensed facilities state-wide. Upon evaluation and deemed medically necessary through the Decision Point Review Pre-certification process all MRI and CAT scan, and electro-diagnostic testing appointments will be scheduled within 24 hours of approval.

Raytel Imaging has been certified through the National Committee for Quality Assurance (NCQA). Raytel Imaging is an approved part of a workers compensation managed care organization pursuant to N.J.A.C. 11:6