



10 East Stow Road - Suite 100  
Marlton, New Jersey 08053  
856.596.5600 P  
856.596.6300 F  
[PremierPrizm.com](http://PremierPrizm.com)

«DateDocument»

«PersonName\_To»  
«Address\_Claimant»

RE: «PersonName\_Claimant»  
Claim #: «ClaimNumber»  
DOL: «DateLoss»

«Dear»

Personal Injury Protection (PIP) is the portion of the auto policy that provides coverage for medical expenses. These medical expenses are subject to policy limits, deductibles, co-payment's and any applicable medical fee schedules. Additionally, these medical expenses must be for services that are deemed medically necessary and causally related to the motor vehicle accident. With the adoption of the Automobile Cost Reduction Act of 1998, several important changes have been made in the way a claim is processed. Additional information regarding Decision Point Review/Pre-Certification can be accessed on the Internet at the New Jersey Department of Banking and Insurance's website at <http://www.nj.gov/dobi/filings.htm>.

Premier Prizm Solutions, LLC has been selected by *Amica Insurance* to implement their plan as required by the Automobile Cost Reduction Act. Premier Prizm will review treatment plan requests for Decision Point Review/Pre-Certification, perform Medical Bill Repricing and Audits of provider bills, coordinate Independent Medical Exams and Peer Reviews, and provide Case Management Services.

If certain medically necessary services are performed without notifying *Amica Insurance* or Premier Prizm, a penalty/co-payment may be applied. Medical care rendered in the first 10 days following the covered loss or any care received during an emergency situation is not subject to Decision Point Review/Pre-certification.

**The Plan Administrator of this plan is:**

Premier Prizm Solutions LLC  
10 East Stow Road  
Suite 100  
Marlton, NJ 08053  
Phone Number: 856-596-5600  
Fax Number: 856-596-6300  
Email address: [AICRA@PremierPrizm.com](mailto:AICRA@PremierPrizm.com)

**Submission of Treatment Plan Requests for Decision Point Review/Pre-Certification**

Please bring the attached "Attending Provider Treatment Plan" form to your treating provider for completion. This completed form along with any applicable medical documentation should be forwarded to Premier Prizm by fax (856-596-6300), or mail (10 East Stow Road Suite 100 Marlton, NJ 08053) or email to [TreatmentRequests@PremierPrizm.com](mailto:TreatmentRequests@PremierPrizm.com). This form can be accessed on Premier Prizm's web site at [www.PremierPrizm.com](http://www.PremierPrizm.com). Any questions regarding your treatment request can be directed to Premier Prizm at 856-596-5600 during regular business hours of Monday through Friday 8:00 AM to 5:00 PM, EST except for Federally Declared Holidays.

### ***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, known as **Care Paths**, for soft tissue injuries, collectively referred to as **Identified Injuries**. Additionally, guidelines for certain diagnostic tests have been established by the New Jersey Department of Banking and Insurance according to N.J.A.C. 11:3-4. *Decision Points* are intervals within the Care Paths where treatment can be evaluated for a decision about the continuation or choice of further treatment. At Decision Points, the eligible injured person or the health care provider must provide Premier Prizm with information regarding further treatment the health care provider intends to provide.

In accordance with N.J.A.C. 11:3-4.5, the administration of any of the following diagnostic tests is subject to Decision Point Review, regardless of diagnosis.

### ***Diagnostic Tests which are subject to Decision Point Review according to N.J.A.C. 11:3-4.5***

1. Needle Electromyography (EMG)
2. Somatosensory Evoked Potential (SSEP)
3. Visual Evoked Potential (VEP)
4. Brain Audio Evoked Potential (BAEP)
5. Brain Evoked Potentials (BEP)
6. Nerve Conduction Velocity (NCV)
7. H-Reflex Studies
8. Electroencephalogram (EEG)
9. Videofluoroscopy
10. Magnetic Resonance Imaging (MRI)
11. Computer Assisted Tomograms (CT, CAT Scan)
12. Dynatorn/Cybox Station/Cybox Studies
13. Sonogram/Ultrasound
14. Brain Mapping
15. Thermography/Thermograms

### ***Pre-Certification***

Pursuant to N.J.A.C. 11:3-4.7, the New Jersey Department of Banking and Insurance, Premier Prizm's Pre-Certification Plan requires pre-authorization of certain treatment/diagnostic tests or services. Failure to pre-certify these services may result in penalties/co-payments even if services are deemed medically necessary. If the eligible injured person does not have an Identified Injury, your treating provider is required to obtain Pre-Certification of treatment, diagnostic tests, services, prescriptions, durable medical equipment or other potentially covered expenses as noted below:

1. Non-emergency inpatient and outpatient hospital care
2. Non-emergency surgical procedures
3. Extended Care Rehabilitation Facilities
4. 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 Path's.
5. Physical, Occupational, Speech, Cognitive, Rehabilitation or other restorative therapy or therapeutic or body part manipulation except as provided for identified injuries in accordance with decision point review.
6. Outpatient psychological/psychiatric treatment/testing or other services
7. All pain management services except as provided for identified injuries in accordance with decision point review
8. Home Health Care
9. Acupuncture
10. Durable Medical Equipment (including orthotics or prosthetics) with a costly or monthly rental in excess of \$100.00



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11. Non-Emergency Dental Restorations
12. Temporomandibular disorder; any oral facial syndrome

### **Decision Point Review Pre-Certification Process**

On behalf of *Amica Insurance* Premier Prizm will review all treatment plan requests and medical documentation submitted. A decision will be rendered within three business days of receipt of a completed Attending Provider Treatment Plan Form request with supporting medical documentation. If additional information is requested, the decision will be rendered within three days of our receipt of the additional information. In the event that *Amica Insurance* or Premier Prizm does not receive sufficient medical information accompanying the request for treatment, diagnostic tests or services to make a decision, an administrative denial will be rendered, until such information is received. If a decision is not rendered within three business days of receipt of an "Attending Provider Treatment Plan" form, your treating health care provider may render medically necessary treatment until a decision is rendered.

Please note that the denial 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.

### **Voluntary Pre-Certification**

We encourage you to participate in a voluntary pre-certification process by bringing a treatment plan request form to your provider or have them contact us for all services requested. Premier Prizm will utilize nationally accepted criteria to authorize a mutually agreeable course of treatment. In consideration for your participation in this voluntary pre-certification process, the bills your provider submits, when consistent with the agreed plan, will not be subject to review or audit as long as they are in accordance with the policy limits, deductibles, and any applicable PIP fee schedule. This process increases the communication between the patient, provider and Premier Prizm to develop a comprehensive treatment plan with the avoidance of unnecessary interruptions in care.

### **Independent Medical Examinations**

Premier Prizm or *Amica Insurance* may request an Independent Medical Examination. At times, this examination may be necessary to reach a decision in response to the treatment plan request by the treating provider. This examination will be scheduled with a provider in the same discipline and at a location reasonably convenient to the injured person. Premier Prizm will schedule the appointment for the examination within 7 days of the day of the receipt of the request unless otherwise agreed by the insured/designee to extend the time frame. Medically necessary treatment may proceed while the examination is being scheduled and until the Independent Medical Examination results become available. Upon completion of the Independent Medical Examination, your provider will be notified of the results via fax or mail within three business days of the examination. A copy of the examining report is available to you or your treating provider upon request.

Premier Prizm will notify you or your designee and the treating provider of the scheduled physical examination and of the consequences for unexcused failure to appear at two or more appointments. If you, the injured party have two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to you or your designee, and all the providers treating you for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form. This 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 physicians treatment plan form will not be reimbursable as a consequence for failure to comply with the plan.

### **Voluntary Network Services**

Premier Prizm has established a network of approved vendors for diagnostic imaging studies for all MRI's and Cat Scans, durable medical equipment with a cost or monthly rental over \$100.00, prescription drugs and all electrodiagnostic testing, listed in N.J.A.C 11:3-4.5(b) 1-3, (unless performed in conjunction with a needle EMG by your treating provider). If you, the injured party utilize one of the pre-approved networks, the 30% co-payment will be waived. If any of the electro-diagnostic tests listed in N.J.A.C 11:3-4.5(b) are performed by the treating provider in conjunction with the needle EMG, the 30% co-payment will not apply. In cases of prescriptions, the \$10.00 co-pay of *Amica Insurance* will be waived if obtained from one of the pre-approved networks.

For *diagnostic tests* of MRI's and Cat Scans, the approved voluntary network that can be utilized is either *Atlantic Imaging*. Once a diagnostic test that is subject to pre-approval through Decision Point Review/ Pre-Certification is authorized, a representative of Premier Prizm will contact the vendor and forward the information to them for scheduling purposes. A representative from the diagnostic facility will contact you, the injured party and schedule the test at a time and place convenient to them.

For *Durable Medical Equipment* with a cost or monthly rental over \$100.00, the approved network is *Progressive Medical, Inc.* Once a request for Durable Medical Equipment that is subject to pre-approval through Decision Point Review/Pre-Certification is authorized, a representative of Premier Prizm will contact Progressive Medical and forward the information to them. The equipment will be shipped to you, the injured party from Progressive Medical, 24 hours after the request is received.

When you are in need of *prescription* drugs, the approved network is My Matrix or Jordan Reese. A pharmacy card will be issued that can be presented at numerous participating pharmacies. A list of participating pharmacies will be mailed to you once the need for a prescription has been identified.

For *Electrodiagnostic Testing*, the approved networks are One Call or Atlantic Neurodiagnostic Group. Once an electro diagnostic test that is subject to pre-approval through Decision Point Review/ Pre-Certification is authorized, a representative of Premier Prizm will contact one of the these vendors and forward the information to them for scheduling purposes. A representative from the diagnostic facility will contact you, the injured party and schedule the test at a time and place convenient to them. When Electrodiagnostic tests are performed by your treating provider, in conjunction with a needle EMG, the 30% co-payment will not apply.

### **Penalty Notification**

Failure to submit request for Decision Point Review or Pre-Certification where required, or failure to submit clinically supported findings that support the treatment, diagnostic testing, or durable medical goods requested will result in a co-payment of 50%. This co-payment is in addition to any co-payment stated in the insured's policy.



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## **Assignment of Benefits**

Health care providers that accept assignment for payment of benefits should be aware that they are required to hold harmless you, the injured person, insured or the insurance carrier for any reduction of benefits caused by the provider's failure to comply with the terms of the decision point/pre-certification plan. In addition, your treating provider must agree to submit disputes to our Internal Appeals Process prior to submitting any disputes through the National Arbitration Forum as per N.J.A.C. 11:3-5. Failure to comply with the Decision Point Review/Pre-Certification Plan or the Requirements to follow the Internal Appeals Process prior to filing litigation including arbitrations will void any and all prior assignment of benefits under this policy.

## **Internal Appeal Process**

### ***Appeals Regarding a Decision Related to a Treatment Request***

Your treating provider may request an internal appeal on any modified or denied services or other matters related to the treatment or care of you the injured person. For appeals regarding a decision related to a treatment request, notification to Premier Prizm needs to occur within 10 business days of the receipt of the decision in question. This appeal must be made in writing by fax, mail or by accessing the Internal Appeals Form on the web site at which point further documentation can be discussed with a physician advisor. This appeal must contain the treating provider's signature and the reason for the appeal. Premier Prizm's response to the appeal will be communicated to the requesting provider in writing by fax within ten business days of the receipt. An Internal Appeals Form can be accessed on Premier Prizm's web site at [www.PremierPrizm.com](http://www.PremierPrizm.com)

### ***Appeals Regarding any Issue other than a Decision Related to a Treatment Request***

Your treating provider may request an internal appeal for any and all issues. These issues may include, but are not limited to, bill review or payment for services. This appeal must be signed by the treating provider and submitted in writing stating the issues being disputed along with supporting documentation. Premier Prizm's written response to this appeal will be communicated to the requesting provider by fax or mail within 10 business days of the receipt of the request. If the treating provider has a valid assignment of benefits, this appeal must be submitted to Premier Prizm 21 days prior to the initiation of any arbitration or litigation.

Submission of an appeal through the Internal Appeals Process as stated above is required for any treating provider who has accepted an assignment of benefits. Should the assignee choose to retain an attorney to handle the Appeals Process, they do so at their own expense.

## **Dispute Resolution Process**

If there is any dispute that is not resolved at the Internal Appeals Process, it may be submitted through the Personal Injury Protection Dispute Process (N.J.A.C. 11:3-5). This can be initiated by contacting the National Arbitration Forum at 1-732-271-6100. **Failure to utilize the Internal Appeal Process prior to filing arbitration or litigation will invalidate an Assignment of Benefits.**

The staff at Premier Prizm remains available to you and your doctor in order to assist with the Decision Point Review/Pre-Certification Process.

Sincerely,

Premier Prizm Solutions, LLC.  
«Distribution»

## ATTENDING PROVIDER TREATMENT PLAN

INITIAL SUBMISSION       FOLLOW-UP SUBMISSION

<b>TYPE OR PRINT LEGIBLY</b>			<b>CLAIM #:</b>			<b>DATE SUBMITTED</b>	Month	Day	Year		
<b>PATIENT INFORMATION</b>						<b>POLICYHOLDER INFORMATION (if different)</b>					
1. PATIENT'S NAME Last      First      Initial			12. DATE OF ACCIDENT			15. POLICYHOLDER'S NAME Last      First      Initial					
2. PATIENT'S ADDRESS (No., Street)			13. IS PATIENT'S CONDITION RELATED TO: A. EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO			16. POLICYHOLDER'S ADDRESS (No., Street)					
3. CITY		4. STATE	B. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			17. CITY			18. STATE		
5. ZIP CODE		6. TELEPHONE # (Include Area Code)				19. TELEPHONE # (Include Area Code)			20. ZIP CODE		
7. PATIENT BIRTHDATE	8. SEX <input type="checkbox"/> M <input type="checkbox"/> F	9. S.S. NUMBER		C. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		21. RELATIONSHIP TO PATIENT					
10. INSURANCE COMPANY			14. IS PATIENT UNABLE TO WORK? <input type="checkbox"/> NO <input type="checkbox"/> YES								
11. POLICY NUMBER											
<b>PROVIDER INFORMATION</b>											
22. NAME OF TREATING PROVIDER Last      First      Initial			23. TAX I.D. NUMBER			24. SPECIALTY		25. FACILITY OR OFFICE NAME			
26. FACILITY/OFFICE ADDRESS (No.; Street)			27. CITY			28. STATE		29. ZIP CODE			
30. TELEPHONE # (Include Area Code)		31. EMAIL ADDRESS			32. FAX # (Include Area Code)		33. INITIAL DATE OF TX		34. DATE OF LAST VISIT		
35. PATIENT MEDICAL HISTORY. HAS PATIENT EVER HAD ANY OF THE FOLLOWING SERVICES? CHECKMARK THOSE APPLICABLE BELOW. (*NOTE-ALL BOXES CHECKED REQUIRE A BRIEF DESCRIPTION OF SERVICE AND DATE PROVIDED ON SEPARATE ATTACHMENT)											
<input type="checkbox"/> ALL MEDICATION		<input type="checkbox"/> MRI		<input type="checkbox"/> SURGERY		<input type="checkbox"/> X-RAY		<input type="checkbox"/> DIAGNOSTICS TESTING		<input type="checkbox"/> OTHER	
36. PRIMARY DIAGNOSIS (ICD-9)		37. SECONDARY DIAGNOSIS (ICD-9)		38. ADDITIONAL DIAGNOSIS (ICD-9)		39. ADDITIONAL DIAGNOSIS (ICD-9)					
<b>PROPOSED COURSE OF TREATMENT AS IT RELATES TO THIS MVA</b>											
40. DATE(S) OF TREATMENT REQUESTED FROM      TO			41. CHECK APPROPRIATE CARE PATH (If applicable) <input type="checkbox"/> CP1 <input type="checkbox"/> CP2 <input type="checkbox"/> CP3 <input type="checkbox"/> CP4 <input type="checkbox"/> CP5 <input type="checkbox"/> CP6								
42. REQUEST FOR SERVICES : CPT / HCPCS / NDC CODES (Use left box for single codes or left and right box for a range of codes)				FREQUENCY (Times per visit)		FREQUENCY (Visits per week)		DURATION (Number of weeks)		TOTAL UNITS	
42. CHECKMARK ATTACHMENTS BELOW. (*NOTE-ALL SUPPORTING DOCUMENTS CHECKED <b>MUST</b> BE PROVIDED ON SEPARATE ATTACHMENT)											
<input type="checkbox"/> SOAP NOTES		<input type="checkbox"/> PROGRESS NOTES		<input type="checkbox"/> TEST RESULTS		<input type="checkbox"/> MEDICAL HISTORY		<input type="checkbox"/> PRESCRIPTIONS		<input type="checkbox"/> OTHER	

### FRAUD PREVENTION-NEW JERSEY WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

#### PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED AND REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

43.

SIGNATURE OF PROVIDER

DATE