

Mercury Insurance Group

**Precertification/Decision Point
Review Plan**

**Inclusive of Precertification
Requirement**

September 2009

Company Confidential

MERCURY INSURANCE GROUP DECISION POINT & PRECERTIFICATION PLAN

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, collectively referred to as the *Identified Injuries*. (For a list of Identified Injuries by ICD-9 codes, see Exhibit A). The *Care Paths* provide that treatment be evaluated at certain intervals called *Decision Points*. On the *Care Paths*, *Decision Points* are represented by hexagonal boxes. At decision points the *Named Insured, Eligible Injured Person* or treating health care provider must provide us information about further treatment that is intended to be *provided (Decision Point Review)*; however the insured may be required to inform the insurer about the injury and the claim, including the information from the insured regarding the facts of the accident, nature and cause of the injury, diagnosis, and anticipated course of treatment. In addition, the administration of any diagnostic tests set forth in N.J.A.C. 11:3-4.5(b) is subject to *Decision Point Review* regardless of the diagnosis. The *Care Paths* and accompanying rules, are attached, are available on the Internet on the Department's website or available by calling Premier Prizm Solutions, LLC, at 856-596-5600

We will advise *Named Insured and/or Eligible Injured Person* of the Care Path requirements upon notification to us of a claim filed under Personal Injury Protection. The Decision Point Review requirements do not apply to treatment administered in Emergency Care or within 10 days of the insured event. The insured may be required to inform the insurer about the injury and the claim, including the information from the insured regarding the facts of the accident, nature and cause of the injury, diagnosis, and anticipated course of treatment. This provision shall not be construed so as to require reimbursement of tests or treatment that is not medically necessary.

Mercury Insurance Group's vendor, **Premier Prizm Solutions**, has established networks of pre-approved vendors which can be recommended for the provision of certain services, diagnostic tests, prescription supplies, and/or durable medical equipment. These pre-approved vendors are tested and monitored to ensure that the highest of quality in goods and services are provided. **Named Insureds and/or Eligible Injured Persons** are encouraged, but not required, to obtain certain services, diagnostic tests, prescription supplies, and/or durable medical equipment from one of the pre-approved vendors. If they use a pre-approved vendor from one of these networks for medically necessary goods or services, they will be fully reimbursed for those goods and services consistent with the policy. If they 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. Additionally, your policy deductible and policy co-payment will be waived.

We will review the course of treatment at various intervals (**Decision Points**), unless a comprehensive treatment plan has been precertified by us. In order for us to determine if additional treatment or the administration of a test is medically necessary, the treating provider or *Named Insured and/or Eligible Injured Person* must provide us with reasonable prior notice together with the appropriate clinically supported findings that the anticipated treatment or test is medically necessary. The insured may be required to inform the insurer about the injury and the claim, including the information from the insured regarding the facts of the accident, nature and cause of the injury, diagnosis, and anticipated course of treatment.

In order for Premier Prizm Solutions, LLC to complete their review, you are required to submit all requests on the **Attending Provider Treatment Plan** form in accordance with DOBI Order No. A04-143. A copy of this form can be found on the DOBI website: <http://www.nj.gov/dobi/ORDERS/treatmentform.pdf>. Decision point and precertification reviews shall be requested by accessing Premier Prizm Solutions, LLC website at www.Premierprizm.com and completing the attached Attending Provider Treatment plan form. You may also contact Premier Prizm Solutions, LLC by telephone at 856-596-5600.

We will review this notice and supporting materials within three business days after receipt of such. Following our review, we have the option to:

- a. Authorize or deny reimbursement for the treatment or test; or
- b. Modify the request; or
- c. Schedule a physical examination of the ***Named Insured and/or Eligible Injured Person*** where the notice and supporting materials are insufficient to authorize or deny reimbursement for the further treatment or test.
- d. Request additional medical records.

If we request a physical examination:

- a. This examination will be scheduled within seven calendar days of our receipt of the notice of additional treatment or tests, unless the ***Named Insured and/or Eligible Injured Person*** agrees to extend the time period;
- b. The medical examination will be conducted by a provider in the same discipline as the treating provider;
- c. The examination will be conducted at a location reasonably convenient for the ***Named Insured and/or Injured Person***; and
- d. At our request, the ***Named Insured and/or Eligible Injured Person*** must provide medical records and other pertinent information to the examining provider no later than the time of the examination or before the scheduled examination.
- e. If the ***Eligible Injured Person*** has two or more unexcused failures to attend the scheduled examination, notification will be immediately sent to the ***Eligible Injured Person*** or his/her designee, and all providers treating the ***Eligible Injured Person*** for the diagnosis (and related diagnosis) contained in the Attending Provider Treatment Plan form. The notification will place the ***Eligible Injured Person*** 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.
- f. Medically necessary treatment may continue while the exam is being scheduled and until the results of the exam become available. This provision shall not be construed so as to require reimbursement of tests or treatment that is not medically necessary.
- g. A copy of the examining providers' report is available upon request.

We will notify the ***Named Insured and/or Eligible Injured Person*** of our decision to authorize or deny reimbursement of the treatment or test as promptly as possible, but no later than three business days following the examination. The ***Named Insured and/or Eligible Injured Party*** or his designee may request a copy of any written report prepared in conjunction with any physical examination we request. If we fail to take any action or fail to respond to the ***Named Insured and/or Eligible Injured Person*** within three business days after receiving the required notification and supporting medical documentation at a decision point, then the

provider is permitted to continue the course of treatment until we provide the required notice. Any denial of the decision point review request based upon 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.

An additional co-payment of 50 percent will apply to the eligible charges for medically necessary treatments, diagnostic tests, or durable medical equipment that are incurred after notification to us is required but prior to our authorization for continued treatment or administration of a test for:

- a. Failure to submit requests for Decision Point Review where required
- b. Failure to provide clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested.

MANDATORY PRECERTIFICATION

If the ***Named Insured and/or Eligible Injured Person*** does not have an Identified Injury, we will require that the ***Named Insured and/or Eligible Injured Person*** or their health care provider request precertification for services, treatments and procedures outlined in Exhibit B which includes: diagnostic tests, prescription supplies, durable medical equipment or otherwise potentially covered medical expense benefits. In the event that a ***Named Insured and/or Eligible Injured Person*** is injured in an automobile accident, the ***Named Insured and/or Eligible Injured Person*** or their health care provider should contact a Mercury Insurance Group claims representative for the toll-free number to call in order to obtain precertification.

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

- All non-emergency in-patient and out-patient hospital services
- Non-emergency Field Nursing Services provided by a LPN and/or a RN
- All non-emergency surgical procedures
- Home Health Care
- Physical, Occupational, Speech, Cognitive or other restorative therapy or other body part manipulation except that provided for Identified Injuries provided for in accordance with Decision Point Review
- Durable Medical Equipment (including orthotics and prosthetics) costing more than \$50.00 or rental greater than 30 days
- Outpatient Psychological/Psychiatric testing and/or services
- All Pain Management Services except as provided for Identified Injuries in accordance with Decision Point Review
- Prescription Drugs costing more than \$50.00
- Non-emergency dental restoration
- Infusion therapy
- Temporomandibular disorders, any oral facial syndrome
- Bone scans
- Vax-D

In order for Premier Prizm Solutions, LLC to complete their review, you are required to submit all requests on the **Attending Provider Treatment Plan** form in accordance with DOBI Order No. A04-143. A copy of this form can be found on the DOBI website: www.nj.gov/dobi/ORDERS/treatmentform.pdf. Decision point and precertification reviews shall be requested by accessing Premier Prizm Solutions, LLC website at www.Premierprizm.com and

completing the attached Attending Provider Treatment plan form. You may also contact Premier Prizm Solutions, LLC by telephone at 856-596-5600.

Please note that no **Precertification** requirements shall apply within ten (10) days of the insured event or to treatment administered in emergency care. This provision should not be construed so as to require reimbursement of tests and treatment that are not medically necessary.

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. The **Named Insured and/or Eligible Injured Person** or their health care provider must provide us with reasonable prior notice of the anticipated services, treatments and procedures as outlined above, as well as, the appropriate clinically supported findings to facilitate timely approval. When appropriate, the health care provider may submit a comprehensive treatment plan for precertification.

Mercury Insurance Group's vendor, **Premier Prizm Solutions, LLC** has established networks of pre-approved vendors which can be recommended for the provision of certain services, diagnostic tests, prescription supplies, and/or durable medical equipment. These pre-approved vendors are tested and monitored to ensure that the highest of quality in goods and services are provided. **Named Insured and/or Eligible Injured Person** are encouraged, but not required, to obtain certain services diagnostic tests, prescription supplies, and/or durable medical equipment from one of the pre-approved vendors. If they use a pre-approved vendor from one of these networks for medically necessary goods or services, they will be fully reimbursed for those goods and services consistent with the policy. If they 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. Additionally, your policy deductible and policy co-payment will be waived.

Once we receive prior written notice with clinically supported documentation we will promptly review the notice and supporting materials and notify the insured of our determination three (3) business days after receipt of such. Following our review, we have the option to:

- a. Authorize or deny reimbursement for the treatment or test; or
- b. Modify the request; or
- c. Schedule a physical examination of the **Named Insured and/or Eligible Injured Person** where the notice and supporting materials are insufficient to authorize or deny reimbursement for the further treatment or test; and/or
- d. Request additional medical records.

If we request a physical examination:

- a. This examination will be scheduled within seven calendar days
Of our receipt of the notice of additional treatment or tests, unless the **Named Insured and/or Eligible Injured Person** agrees to extend the time period;
- b. The medical examination will be conducted by a provider in the same discipline as the treating provider;

- c. The examination will be conducted at a location reasonably convenient for the ***Named Insured and/or Injured Person***; and
- d. At our request, the ***Named Insured and/or Eligible Injured Person*** must provide medical records and other pertinent information to the examining provider no later than the time of the examination or before the scheduled examination.
- e. If the ***Eligible Injured Person*** has two or more unexcused failures to attend the scheduled examination, notification will be immediately sent to the ***Eligible Injured Person*** or his/her designee, and all providers, treating the ***Eligible Injured Person*** for the diagnosis (and related diagnosis) contained in the Attending Provider Treatment Plan form. The notification will place the ***Eligible Injured Person*** 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.
- f. Medically necessary treatment may continue while the exam is being scheduled and until the results of the exam become available. This provision shall not be construed so as to require reimbursement of tests or treatment that is not medically necessary.
- g. A copy of the examining providers' report is available upon request.

We will notify the ***Named Insured and/or Eligible Injured Person*** of our decision to authorize or deny reimbursement of the treatment or test as promptly as possible, but no later than three business days following the examination. The ***Named Insured and/or Eligible Injured Party*** or his designee may request a copy of any written report prepared in conjunction with any physical examination we request. If we fail to take any action or fail to respond to the ***Named Insured and/or Eligible Injured Person*** within three business days after receiving the required notification and supporting medical documentation for precertification, then the provider is permitted to continue the course of treatment until we provide the required notice. Any denial of the precertification request based upon 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.

An additional co-payment of 50 percent will apply to the eligible charge 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 the insurer has an opportunity to respond in accordance with its approved **precertification plan** for:

- a. Failure to submit requests for Precertification as required
- b. Failure to submit clinically supported findings that support the treatments, diagnostic tests or durable medical equipment or goods requested.

The insured may be required to inform the insurer about the injury and the claim, including the information from the insured regarding the facts of the accident, nature and cause of the injury, diagnosis, and anticipated course of treatment. This information may be required to be provided as promptly as possible after the accident, and periodically thereafter. An additional co-payment penalty shall be applied for failure to supply the required information. Such penalty shall result in a reduction in the amount of reimbursement of the eligible charge for medically necessary expenses that are incurred after notification to the insurer is required and until notification is received. The additional co-payment shall be an amount no greater than 25% when received 30 or more days after the accident; or 50% when received 60 or more days after the accident. Any reduction in the amount of reimbursement for PIP claims shall be in addition to any other deductible or co-payment requirement.

VOLUNTARY PRECERTIFICATION

Health care providers are encouraged to participate in a voluntary precertification process by providing Premier Prizm Solutions, LLC with a comprehensive treatment plan for identified and non-identified injuries.

Premier Prizm Solutions, LLC will utilize nationally accepted criteria the Medical Protocols in NJAC 11:3-4, to work with the health care provider and 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 and deemed medically necessary, 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 and the review requirements. In addition, having an approved treatment plan means that as long as treatment is consistent with the Voluntary Pre-certification Plan, additional notification to Premier Prizm Solutions, LLC is not required at Decision Points or for treatment, diagnostic tests or durable medical equipment requiring precertification.

PRECERTIFICATION PROCESS

For every claim that is reported by a ***Named Insured and/or Eligible Injured Person***, a loss report is created and transmitted electronically to our claim office. A claim representative contacts the ***Named Insured and/or Eligible Injured Person***, confirms coverage and reviews policy requirements. During this conversation, the claim representative explains decision point review and that precertification is required for the services, treatments and procedures outlined Exhibit B. Our vendor, Premier Prizm Solutions, LLC will provide assistance as the ***Named Insured and/or Eligible Injured Person*** proceeds through their course of treatment. The ***Named Insured and/or Eligible Injured Person*** is advised that he/she will be contacted by Premier Prizm Solutions, LLC within 24 hours of receiving a referral from Mercury Insurance. The ***Named Insured and/or Eligible Injured Person*** is provided with the toll free number to call with any questions they may have regarding the decision point review and precertification process.

Nurse Case Managers are available 8:30 AM to 5:00 PM EST Monday through Friday. A direct number, 856-596-5600 is available for the ***Named Insured and/or Eligible Injured Person*** or their provider to call with any questions pertaining to the medical portion of the claim. During this telephone consultation, an attempt is made by Premier Prizm Solutions, LLC to:

- Establish a detailed account of the injury without duplicating the information electronically transferred by Mercury Insurance Group
- Identify medical providers currently active on the case
- Provide educational assistance in regard to precertification

Each person will have a Nurse Case Manager assigned to their case who can answer medical or billing questions pertaining to the claim. For all other questions concerning their claim, the ***Named Insured and/or Eligible Injured Person*** should contact their claim representative.

Voluntary Networks

Mercury Insurance Group's vendor, Premier Prizm Solutions, LLC, has established networks of pre-approved vendors which can be recommended for the provision of certain services, diagnostic tests, i.e., magnetic resonance imagery, computer assisted tomography, the electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b) 1 through 3 except when performed in

conjunction with a needle EMG by the treating physician, durable medical equipment with a cost or monthly rental in excess of \$50.00; or prescription drugs and durable medical equipment supplies. These pre-approved vendors are tested and monitored to ensure that the highest of quality in goods and services are provided. You are encouraged, but not required, to obtain certain services, diagnostic tests, prescription drugs, and/or durable medical equipment 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. Additionally, your policy deductible and policy co-payment will be waived. 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.

Those designated providers are the following:

- AIG Network for Diagnostics
- MYMATRIXX for Pharmacy
- Progressive for Durable Medical Equipment

All above providers are approved licensed or certified as an organized delivery system pursuant to N.J.A.C. 11:22-4 or 8:38B.

Durable Medical Equipment – The above listed DME vendors provide for purchase or rental of equipment. They all offer a wide selection of equipment at a reasonable price. They will ship to and provide service in all 50 states. The RN case manager assists in this process by obtaining a prescription from the treating provider who notes specific items needed to aid the eligible injured person in recovery. If rented, the RN case manager periodically checks with the eligible injured person to see if equipment is still being used. If not, the supplying vendor will pick up the equipment and credit it to the insurer's "bank."

Prescriptions – Eligibility information is sent via fax or E-mail. The vendor will provide a brochure describing the program with the list of participating pharmacies. The eligible injured person may also call a toll free customer service help desk to find participating pharmacies in their geographic area. Mail order is also available.

Diagnostic Testing – Innovative Claims Strategies' diagnostic testing and imaging networks are dedicated to providing superior services to the eligible injured person. The centers are conveniently located throughout the State with outstanding Board-Certified Radiologists and Board Certified Neurologists who provide reports in twenty-four hours. Referrals are scheduled promptly within three business days. Emergency cases are scheduled on a priority basis. Weekend and night scheduling is also available.

PPO Networks – These networks include providers in all specialties, hospitals, outpatient facilities, urgent care centers, rehabilitation facilities, and physical therapy providers throughout the entire State. The use of these networks is strictly voluntary and the choice of a health care provider is always made by ***the Named Insured and/or Eligible Injured Person***.

All bills for medical services will be received at the Premier Prizm Solutions, LLC office. The bills will be entered into the Utilization Review/Bill Review system and matched against the information entered into the system by the Nurse Case Manager and the Medical Director. The bills will be processed for payment if they match treatment authorized as indicated in the system. If any information differs, including diagnosis, CPT coding and services rendered, the bills will be

referred to the Nurse Case Manager for utilization review. Where Fee Schedule, UCR, RN Code Review and PPO or Large Bill Negotiation/Audit procedures are adhered to, after which precertification rules are reviewed - all bills are paid as required within the State guidelines within 60 days of the receipt of a "clean" bill or interest is paid.

Any bills for services approved by utilization review will be processed for payment and will include any applicable deductible and/or co-payments. Denial would warrant referral to the Medical Director/Physician Advisor for review and whose decision will be forwarded to the Eligible Injured Person.

3-Level Utilization Review Process

1. First Level of Clinical Review – The title of the person performing first level clinical reviews is Nurse Reviewer. All persons in the Nurse Reviewers position are licensed by the State of New Jersey Board of Nursing as Licensed Practical or Licensed Registered Nurses.

In the first level of review, the RN/LPN will review all diagnosis codes and current procedural terminology (CPT) against the treatment and testing recommendations. The Utilization Review/Bill Review System will be diaried for review 10 days post accident, the start of the decision point review/precertification program.

Medical documentation will be reviewed on an ongoing basis. Required medical documentation from the treating provider must include documented results of the initial and subsequent evaluations to include an assessment of any current and/or historical subjective complaints, observations, objective findings, neurological indications, and physical tests. All previously performed tests that relate to the injury and the results must be considered in writing.

Anticipated discharge will be reviewed to verify the established treatment date. If discharge has been extended and/or an additional request for services has been made, any additional medical information needed to complete the review will be requested within two business days. If the RN/LPN approves the requests, the system will be documented. Decision Point Review/Precertification authorization letters will be sent to eligible injured party/provider the next business day. If the RN/LPN cannot make this decision, the file will be routed to the Clinical Peer Provider within one business day to review decision point/precertification criteria.

When services being reviewed do not meet initial review criteria at this level, the reviewer refers it to the Clinical Peer Provider who does a "second level" review. The Nurse Reviewer is supported by the Clinical Peer Provider who has a non-restricted license to practice medicine in the United States. He/She is available by telephone during normal business hours.

2. Peer Clinical Review (Second Level Review) - Second level clinical reviews are conducted only by clinical peer providers who hold a current non-restricted license to practice medicine or a health profession in the United States. Nurses who review cases are required to refer any case that does not meet criteria to the Clinical Peer Provider for review. The attending provider is notified of this at the time of intake. The Nurse Reviewer prints a case information sheet and gives it to the Clinical Peer Provider for assessment and medical determination. Additional documentation is then requested by the Clinical Peer from the Treatment Provider and should include: initial and subsequent

evaluations to include an assessment of any current and/or historical subjective complaints, observations, objective findings, neurological indications and physical tests.

The Clinical Peer Provider may:

- a. Approve admission or procedure in question based on available information
- b. Consult with the attending physician to determine the need for services and/or treatment, or
- c. Render an adverse decision

In the event that an attending physician, ordering provider, enrollee, injured person, facility, patient, patient representative or other health care provider has additional medical or other information regarding the denial or modification of a Decision Point Review request or a request to precertify any medical treatment, tests, durable medical equipment or prescriptions drugs, or there is any issue relating to bill payment or processing you are entitled to seek an appeal of such decision. He/she/it may submit a written or telephonic request to Premier Prizm, Solutions LLC, within thirty (30) business days of receipt of any non-certification determination to have the additional medical information reviewed via an **Expedited** or **Standard Appeals Process** by a physician/clinical peer who did not make the original determination not to certify. Copies of the medical record documentation supporting the additional medical information must be included with the request for the standard appeal. Our vendor will take into account all documents, records, or other information submitted by the patient, provider, or facility rendering service relating to the case, without regard to whether such information was submitted or considered in the initial consideration of the case. The nurse reviewer and/or Medical Director will make every effort to select a specialist to perform the third level review that is obviously medically qualified by certification and training to deal specifically with the clinical issue under review.

All requests for Appeal shall be considered in accordance with the following timeframes: **Expedited Appeals** are completed as soon as possible, and no later than three (3) business day after the initiation of the appeals process or per State guidelines if less than 3 business days; **Standard Appeals** are completed generally within ten (10) days of receipt of written request, but in no later than fourteen (14) calendar days of the initiation of the appeal process or per State guidelines if less than 14 days.

Upon request, the UR vendor will provide the attending physician / other ordering provider who has been unsuccessful in an attempt to reverse a determination not to certify, patient, and hospital or facility rendering service, the clinical rationale for that determination in writing.

The Physician Advisor / clinical peer will be available within 1 business day to discuss by telephone the determination with the attending physician and/or other ordering provider.

Records will be kept for each appeal that include: Name of the patient, provider, and/or facility rendering service; Copies of all correspondence from the patient, provider, or facility rendering service and UR Vendor regarding the appeal; Dates of appeal reviews, documentation of actions taken, and final resolution.

The Clinical Peer Provider is available through Premier Prizm Solutions, LLC, by telephone at 856-596-5600 between 8:00 a.m. and 5:30 p.m. Eastern Standard Time every business day.

3. Peer Clinical Review: Appeals (Third Level Review) – Third level clinical reviews are conducted only by clinical peers who hold a current non-restricted license to practice medicine or a health profession in the United States. All are Board Certified and in active practice.

The nurse reviewer and/or Medical Director will make every effort to select a specialist to perform the third level review that is obviously medically qualified by certification and training to deal specifically with the clinical issue under review.

If the provider accepts the Physician Advisor's decision, the system will be documented and placed on follow up for the next decision point/precertification review. If the provider decides to appeal, a peer to peer third level review will be conducted within 3 business days. If the peer to peer review is accepted by the provider, the system will be documented accordingly. If the provider disagrees with this decision or if supporting materials are not adequate to authorize or deny further treatment or tests, an independent medical examination may be scheduled.

The claimant will be notified in writing three (3) business days after the appeal has been received for an expedited appeal and 14 (fourteen) calendar days after the appeal has been received for a Standard appeal.

If the provider disagrees with this decision of the Peer Clinical Review: Appeals (Third Level Review) or if supporting materials are not adequate to authorize or deny further treatment or tests, an independent medical examination may be considered. 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. Under Mercury's Assignment of Benefits conditions, a provider who has accepted an assignment of benefits is required to utilize the Internal Appeals Process for these issues, prior to filing a demand for alternative dispute resolution.

If an independent medical examination is required, medically necessary treatment shall proceed while the examination is being scheduled and until the results become available. This provision should not be construed as to require reimbursement of treatment and tests that are not medically necessary.

The eligible injured person will be notified three business days after the exam. The results of the exam will be documented in the system. A copy of the written physical examination report will be made available upon request.

Assignment of Benefits

At our option, medical expense benefits under the policy may be assigned to a health care provider providing the healthcare provider:

1. Complies with the requirements of Mercury's precertification plan and decision point review;
2. Agrees that any disputed issues involving treatment or services provided to the eligible injured person must be resolved through the dispute resolution process

3. Consents to consolidate all arbitrations actions currently pending involving the same eligible injured party or accident
4. Holds harmless the insured and Mercury Insurance Group for any reduction of payment for services caused by provider's failure to comply with the terms of the insured's policy.
5. Complies with the internal appeal process of Mercury's Decision Point Review/Precertification plan. Compliance with the internal appeals process is a condition precedent to arbitration.

Failure to abide by the terms and conditions of assignment will render any assignment null and void.

Prizm Workflow

Premier Prizm Solutions LLC, submits this workflow to implement their Decision Point Review/Pre-Certification Plan.

Notification of event involving an injury:

- When the insured or covered individual is injured, the Injured Party notifies Mercury of the injury. Mercury verifies coverage and eligibility and then sends out an informational packet to the claimant. The informational packet to the insured will include:

- Initial Information Letter to Insured/Claimant/Providers/Attorneys

The claim is referred by Mercury to Premier Prizm with the following information:

- Claim Number
- Claimant Name
- Claimant Address
- Claimant Phone Number
- Policy Information (Deductible, Limits)
- Date of Accident
- Treating Provider Name/Address/Phone Number/Fax Number
- Attorney Information

This information can be forwarded by:

- Phone at 856-596-5600
- Faxed to 856-596-6300 or
- Emailed to Referrals@PremierPrizm.com
- Premier Prizm's Web Site at www.PremierPrizm.com

Trained clerical support personnel enter the information in Section b above into utilization tracking software. Contact is made within 24 business hours to the treating provider requesting the following information:

- Diagnosis (ICD-9)
- Treatment/Testing/Durable Medical Equipment Requested (CPT codes, HCPS codes)
- Frequency and duration of requested treatment/test/or service
- Anticipated start date/end date of proposed treatment/testing/service
- Clinical rationale to support medical necessity of request for treatment/testing/service.
- Previous treatment to date and patient's response
- Any pertinent diagnostic testing and results
- Previous medical history
- Date of Accident
- Clinical symptoms of patient

The provider contacts Premier Prizm by telephone, fax, or email with the information above. The provider can contact Premier Prizm by phone during regular business hours (856-596-5600). Regular business hours are defined as Monday through Friday, except for Federally Declared Holidays, between the hours of 8:00 AM and 5:00 PM, EST. The provider submits the information by returning the Treatment Request form via fax to 856-596-6300, electronically to TreatmentRequests@PremierPrizm.com, or mailed.

Once the Treatment Request is received by Premier Prizm, a Nurse reviews the request for the following:

- The request is reviewed to see if the diagnosis and treatment are part of the "identified injury" and care paths or one of the items listed in Items subject to Pre-Certification.
 - If the request is for one of the "identified injuries" as stated in NJAC 11:3-4.7, the Nurse reviews the request to see if the requested service is part of the medical protocols within the care path. If so, the request is approved. Notification of this decision is made by mail/fax to the requesting provider/claimant/designee/insurer within 3 business days from the time of the receipt of the request by Mercury or Premier Prizm. All requests received are date stamped with the date they are received by Premier Prizm.
 - If the request is for an injured party with one of the "identified injuries" as stated in the NJAC 11:3-4.7, but the request for service is not part of the care path or the request is for one of the pre-certification items, the Nurse will review the request and all medical documentation submitted. The Nurse utilizes clinical expertise along with nationally recognized published criteria to render a decision of medical necessity. If the nurse renders a decision of medical necessity, the provider/claimant/attorney/ insurer are notified within 3 business days of receipt of the request by mail or fax.

- If the service requested does not meet the criteria of being medically necessary, the Nurse forwards this request and all available medical information to the Physician Advisor for review. The Physician Advisor reviews the request and available medical documentation. If additional medical information is necessary, the Physician Advisor may telephone the requesting provider for a phone conference in an effort to attain a consensus treatment plan. Once the Physician Advisor has all of the above information, a decision is rendered. A decision is reached and the requesting provider is notified by fax or mail within 3 business days after the time the request is received or 3 days following receipt of all information by the insurer or Premier Prizm. If the Physician Advisor is unable to render an opinion based on the available documentation and/or a telephone conference with the requesting provider, the physician advisor may request a physical or mental examination. If based on the Physician Advisor's opinion a physical or mental examination is needed to render a decision, an appointment for an IME (of the same discipline and within a location reasonably convenient to the patient) is scheduled within 7 calendar days of the date of the request. It is noted that medically necessary treatment can continue while the IME is being scheduled. Premier Prizm on behalf of Mercury shall notify by mail the injured person or his designee and shall notify by fax the requesting provider whether reimbursement for further treatment or test is authorized as promptly as possible but no later than 3 business days after the examination. A copy of the examining physician's report is available upon request.

- Decisions:

- Approved – A request for treatment/testing/Durable Medical Equipment is approved by either the Nurse or a Physician Advisor (if forwarded to a Physician Reviewer) or as a result of an Independent Medical Examination.
- Denied - A request for treatment/testing/Durable Medical Equipment is denied either by a Physician Advisor or an Independent Medical Examiner.
- Modified- A request for treatment/testing/Durable Medical Equipment is modified either by a Physician Advisor or an Independent Medical Examiner.
- Administrative Denial – If sufficient medical information was not supplied to render a decision, a decision of administrative denial can be rendered either by the Nurse or the Physician Advisor. Upon receipt of the required additional information, the request can be reviewed and a decision will be rendered within three business days.
- Retrospective DOS – If the request for treatment/testing/Durable Medical Equipment is for a Date of Service which has already occurred, a decision of Retrospective DOS will be rendered.

III. Plan Of Operation

Premier Prizm has been contracted by Mercury to implement Decision Point Review/Pre-Certification on their behalf.

Premier Prizm currently maintains multiple phone and fax lines. Additionally, Premier Prizm maintains a 1-800 Number for injured parties, providers, clients etc to contact us. All of Premier Prizm's staff whose job description necessitates the use of email, are assigned an email address.

Premier Prizm's normal business hours are Monday-Friday between the hours of 8:00AM and 5:00 PM, EST except for Federally Declared Holidays.

Premier Prizm has appointed Dr. Daniel Ragone, a Board Certified Physical Medicine and Rehabilitation physician as their Medical Director. Premier Prizm utilizes physician of 'like specialty' to render all decisions which were not deemed medically necessary at the Nurse Level of review.

Premier Prizm maintains an experienced staff performing duties related to the current needs of NJ insurance regulations. This staff includes:

<u>Audit Nurses, Code Review Personnel</u>	<u>12</u>
<u>Bill Repricers</u>	<u>9</u>
<u>Case Managers</u>	<u>6 inc per diem</u>
<u>Clerical Support</u>	<u>35</u>
<u>Pre Cert/Utilization Review Nurses</u>	<u>22</u>
<u>Quality Assurance</u>	<u>2</u>
<u>IT</u>	<u>6</u>
<u>Sales/Account Representative</u>	<u>3</u>

These staff members have the following experience:

PreCert Nurses

- Experienced in the AICRA regulations applicable to NJ Auto (3-4 yrs)
- Experienced in Pre-certification/utilization review/quality assurance (10-15 yrs)
- Experienced in medical clinical knowledge
- Computer literate
- Customer Service Oriented

Pre-Cert Assistants

- Experienced in AICRA regulations applicable to NJ Auto (3-4 yrs)
- Experienced in medical terminology (4-5 yrs)
- Customer Service Oriented
- Computer Literate

Bill Repricers

- Experience in bill repricing according to NJ regulations (2-5 yrs)
- Data entry skills
- Customer Service skills

Case Managers

- Experienced in Field and Telephonic Case Management in NJ (5-20 yrs)
- Experienced in AICRA regulations

Auditors

- Experienced in NJ Regulations (8-25 yrs)
- Experienced in AICRA regulations

Key Management Personnel

Director of Clinical Services

- Experienced in the AICRA regulations applicable to NJ Auto (Since inception)
- Experienced in Pre-certification
- Experienced in Utilization review
- Experienced in Quality assurance

Account Management

- *Experienced in account management*
- *Experienced in NJ Auto Insurance*

President (Director of Operations)

- Experienced in the AICRA regulations applicable to NJ Auto (Since inception)
- Experienced in Implementation of DPR/Pre-certification program
- Experienced in Utilization review
- Experienced in Quality assurance

INITIAL INFORMATION LETTER TO INSURED/CLAIMANT/PROVIDERS/ATTORNEYS

Dear Insured/Claimant/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 and durable medical equipment 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 the information about further treatment that is intended to be provided (this is referred to as **Decision Point Review**); however the insured may be required to inform the insurer about the injury and the claim, including the information from the insured regarding the facts of the accident, nature and cause of the injury, diagnosis, and anticipated course of treatment. In addition, the administration of any diagnostic tests set forth in N.J.A.C. 11:3-4.5(b) is subject to **Decision Point Review** regardless of the diagnosis. The **Care Paths** and accompanying rules are available on the Internet on the Department's website at <http://www.nj.gov/dobi/aicrapg.htm> or available by calling Premier Prizm Solutions, LLC, at 856-596-5600.

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, visual evoked potential brain audio evoked potential, brain evoked potential, nerve condition velocity, and H-reflex study
- Electroencephalogram (EEG)
- Videofluoroscopy
- Magnetic resonance imaging (MRI)
- Computer assisted tomographic studies (CT, CAT scan)
- Dynatron/cyber station/cybex
- Sonograms/ultrasound
- Thermography/thermograms
- Brain mapping when done in conjunction with appropriate neurodiagnostic testing

Please note that the decision point review requirements do not apply to treatment or diagnostic tests administered during emergency care or during the first ten days following the covered accident. This provision should not be construed as to require reimbursement of treatment and tests that are not medically necessary.

We will review this notice and supporting materials within three business days after receipt of such. Following our review, we have the option to:

- a) Authorize or deny reimbursement for the treatment or test; or
- b) Modify the request; or

- c) Schedule a physical examination of the ***Named Insured and/or Eligible Injured Person*** where the notice and supporting materials are insufficient to authorize or deny reimbursement for the further treatment or test.

If we request a physical examination:

- a) This examination will be scheduled within seven calendar days of our receipt of the notice of additional treatment or tests, unless the ***Named Insured and/or Eligible Injured Person*** agrees to extend the time period;
- b) The medical examination will be conducted by a provider in the same discipline as the treating provider;
- c) The examination will be conducted at a location reasonably convenient for the ***Named Insured and/or Injured Person***; and
- d) At our request, the ***Named Insured and/or Eligible Injured Person*** must provide medical records and other pertinent information to the examining provider no later than the time of the examination or before the scheduled examination.
- e) If the ***Eligible Injured Person*** has two or more unexcused failures to attend the scheduled examination, notification will be immediately sent to the ***Eligible Injured Person*** or his/her designee, and all providers treating the ***Eligible Injured Person*** for the diagnosis (and related diagnosis) contained in the Attending Provider Treatment Plan form. The notification will place the ***Eligible Injured Person*** 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.
- f) Medically necessary treatment may continue while the exam is being scheduled and until the results of the exam become available. This provision shall not be construed so as to require reimbursement of tests or treatment that is not medically necessary.
- g) A copy of the examining providers' report is available upon request.

We will notify the ***Named Insured and/or Eligible Injured Person*** of our decision to authorize or deny reimbursement of the treatment or test as promptly as possible, but no later than three business days following the examination. The ***Named Insured and/or Eligible Injured Party*** or his designee may request a copy of any written report prepared in conjunction with any physical examination we request. If we fail to take any action or fail to respond to the ***Named Insured and/or Eligible Injured Person*** within three business days after receiving the required notification and supporting medical documentation at a decision point, then the provider is permitted to continue the course of treatment until we provide the required notice. Any denial of the decision point review request based upon 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.

An additional co-payment of 50 percent will apply to the eligible charges for medically necessary treatments, diagnostic tests, or durable medical equipment that are incurred after notification to us is required but prior to our authorization for continued treatment or administration of a test for:

- a. Failure to submit requests for Decision Point Review where required
- b. Failure to provide clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested.

MANDATORY PRECERTIFICATION

If the ***Named Insured and/or Eligible Injured Person*** does not have an Identified Injury, we will require that the ***Named Insured and/or Eligible Injured Person*** or their health care provider request precertification for services, treatments and procedures outlined in Exhibit B which includes: diagnostic tests, prescription supplies, durable medical equipment or otherwise potentially covered medical expense benefits. In the event that a ***Named Insured and/or Eligible Injured Person*** is injured in an automobile accident, the ***Named Insured and/or Eligible Injured Person*** or their health care provider should contact a Mercury Insurance Group claims representative for the toll-free number to call in order to obtain precertification.

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

- All non-emergency in-patient and out-patient hospital services
- Non-emergency Field Nursing Services provided by a LPN and/or a RN
- All non-emergency surgical procedures
- Home Health Care
- Physical, Occupational, Speech, Cognitive or other restorative therapy or other body part manipulation except that provided for Identified Injuries provided for in accordance with Decision Point Review
- Durable Medical Equipment (including orthotics and prosthetics) costing more than \$50.00 or rental greater than 30 days
- Outpatient Psychological/Psychiatric testing and/or services
- All Pain Management Services except as provided for Identified Injuries in accordance with Decision Point Review
- Prescription Drugs costing more than \$50.00
- Non-emergency dental restoration
- Infusion therapy
- Temporomandibular disorders, any oral facial syndrome
- Bone scans
- Vax-D

In order for Premier Prizm Solutions, LLC to complete their review, you are required to submit all requests on the **Attending Provider Treatment Plan** form in accordance with DOBI Order No. A04-143. A copy of this form can be found on the DOBI website: www.nj.gov/dobi/ORDERS/treatmentform.pdf. Decision point and precertification reviews shall be requested by accessing Premier Prizm Solutions, LLC website at www.Premierprizm.com and completing the attached Attending Provider Treatment plan form. You may also contact Premier Prizm Solutions, LLC by telephone at 856-596-5600.

Please note that no **Precertification** requirements shall apply within ten (10) days of the insured event or to treatment administered in emergency care. This provision should not be construed so as to require reimbursement of tests and treatment that are not medically necessary.

Upon receipt of a request for decision point review we will review this notice and supporting materials within three business days. Following our review, we have the option to:

- a. Authorize or deny reimbursement for the treatment or test; or
- b. Modify the request; or

- c. Schedule a physical examination of the ***Named Insured and/or Eligible Injured Person*** where the notice and supporting materials are insufficient to authorize or deny reimbursement for the further treatment or test; and/or
- d. Request additional medical records.

The insured may be required to inform the insurer about the injury and the claim, including the information from the insured regarding the facts of the accident, nature and cause of the injury, diagnosis, and anticipated course of treatment. The information may be required to be provided as promptly as possible after the accident, and periodically thereafter. An additional co-payment penalty shall be applied for failure to supply the required information. Such penalty shall result in a reduction in the amount of reimbursement of the eligible charge for medically necessary expenses that are incurred after notification to the insurer is required and until notification is received. The additional co-payment shall be an amount no greater than 25% when received 30 or more days after the accident; or 50% when received 60 or more days after the accident. Any reduction in the amount of reimbursement for PIP claims shall be in addition to any other deductible or co-payment requirement.

VOLUNTARY PRECERTIFICATION

Health care providers are encouraged to participate in a voluntary precertification process by providing Premier Prizm Solutions, LLC with a comprehensive treatment plan for identified and non-identified injuries.

Premier Prizm Solutions, LLC will utilize nationally accepted criteria the Medical Protocols in NJAC 11:3-4, to work with the health care provider and 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 and deemed medically necessary, 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 and the review requirements. In addition, having an approved treatment plan means that as long as treatment is consistent with the Voluntary Pre-certification Plan, additional notification to Premier Prizm Solutions, LLC is not required at Decision Points or for treatment, diagnostic tests or durable medical equipment requiring precertification.

PPO Networks

These networks include providers in all specialties, hospitals, outpatient facilities, urgent care centers, rehabilitation facilities, and physical therapy providers throughout the entire State. The use of these networks is strictly voluntary and the choice of a health care provider is always made by ***the Named Insured and/or Eligible Injured Person***.

Voluntary Networks

Mercury Insurance Group's vendor, Premier Prizm Solutions, LLC, has established networks of pre-approved vendors which can be recommended for the provision of certain services, diagnostic tests, i.e., magnetic resonance imagery, computer assisted tomography, the electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b) 1 through 3 except when performed in conjunction with a needle EMG by the treating physician, durable medical equipment with a cost or monthly rental in excess of \$50.00; or prescription drugs and durable medical equipment supplies. These pre-approved vendors are tested and monitored to ensure that the highest of

quality in goods and services are provided. You are encouraged, but not required, to obtain certain services, diagnostic tests, prescription drugs, and/or durable medical equipment 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. Additionally, your policy deductible and policy co-payment will be waived. 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.

Those designated providers are the following:

- AIG Network for Diagnostics
- MYMATRIX for Pharmacy
- Progressive for Durable Medical Equipment

Decision Point Review and Precertification Compliance Requirements

In the event that a named insured or eligible injured person is injured in an auto accident, such person or their health care provider should call 856-596-5600 in order to obtain precertification or decision point review prior to incurring the medical expense.

In order for Premier Prizm Solutions, LLC to complete their review, you are required to submit all requests on the **Attending Provider Treatment Plan** form in accordance with DOBI Order No. A04-143. A copy of this form can be found on the DOBI website: www.nj.gov/dobi/ORDERS/treatmentform.pdf. Decision point and precertification reviews shall be requested by accessing Premier Prizm Solutions' website at www.Premierprizm.com and completing the attached Attending Provider Treatment Plan form. You may also contact Premier Prizm Solutions, LLC by telephone at 856-596-5600.

Appeals

Should the Clinical Peer Provider render an adverse decision the attending physician is advised of the decision by the Clinical Peer Provider of the adverse decision within 48 hours of the reconsideration process. The appropriate adverse decision notifications are processed and directed to the provider and injured party.

In the event that an attending physician, ordering provider, enrollee, injured person, facility, patient, patient representative or other health care provider has additional medical or other information regarding the denial or modification of a Decision Point Review request or a request to precertify any medical treatment, tests, durable medical equipment or prescriptions drugs, or there is any issue relating to bill payment or processing you are entitled to seek an appeal of such decision. He/she/it may submit a written or telephonic request to Premier Prizm, Solutions LLC, within thirty (30) business days of receipt of any non-certification determination to have the additional medical information reviewed via an **Expedited** or **Standard Appeals Process** by a physician/clinical peer who did not make the original determination not to certify. Copies of the medical record documentation supporting the additional medical information must be included with the request for the standard appeal. Our vendor will take into account all documents, records, or other information submitted by the patient, provider, or facility rendering service relating to the case, without regard to whether such information was submitted or considered in the initial consideration of the case. The nurse reviewer and/or Medical Director will make every

effort to select a specialist to perform the third level review that is obviously medically qualified by certification and training to deal specifically with the clinical issue under review.

All requests for Appeal shall be considered in accordance with the following timeframes:
Expedited Appeals are completed as soon as possible, and no later than three (3) business day after the initiation of the appeals process or per State guidelines if less than 3 business days;
Standard Appeals are completed generally within ten (10) days of receipt of written request, but in no later than fourteen (14) calendar days of the initiation of the appeal process or per State guidelines if less than 14 days.

The claimant will be notified in writing three (3) business days after the appeal has been received for an expedited appeal and 14 (fourteen) calendar days after the appeal has been received for a Standard appeal.

If the provider disagrees with this decision of the Peer Clinical Review: Appeals (Third Level Review) or if supporting materials are not adequate to authorize or deny further treatment or tests, an independent medical examination may be considered. 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. Under Mercury's Assignment of Benefits conditions, a provider who has accepted an assignment of benefits is required to utilize the Internal Appeals Process for these issues, prior to filing a demand for alternative dispute resolution.

If an independent medical examination is required, medically necessary treatment shall proceed while the examination is being scheduled and until the results become available. This provision should not be construed as to require reimbursement of treatment and tests that are not medically necessary.

The eligible injured person will be notified three business days after the exam. The results of the exam will be documented in the system. A copy of the written physical examination report will be made available upon request.

Assignment of Benefits

At our option, medical expense benefits under the policy may be assigned to a health care provider providing the healthcare provider who:

1. Complies with the requirements of Mercury's precertification plan and decision point review;
2. Agrees that any disputed issues involving treatment or services provided to the eligible injured person must be resolved through the dispute resolution process
3. Consents to consolidate all arbitrations actions currently pending involving the same eligible injured party or accident
4. Holds harmless the insured and Mercury Insurance Group for any reduction of payment for services caused by provider's failure to comply with the terms of the insured's policy.
5. Complies with the internal appeal process of Mercury's Decision Point Review/Precertification plan. Compliance with the internal appeals process is a condition precedent to arbitration.

Failure to abide by the terms and conditions of assignment will render any assignment null and void.