



CONTACT US

By Phone

Tel: 1-866-548-5127

Fax: 1-888-382-6719

Liberty Insurance Corporation
P.O. Box 515097
Los Angeles, CA 90051-5097

<Addressee1first>
<Addressee2.name> <Addressee
Addrline1> <Addressee.Addrline2>

Patient Name: **First Name Last Name**
Claim Number: **123456789-1234**
Date of Loss: **XX/XX/XXXX**

Dear Medical Professional,

This letter is to advise you that Medlogix,LLC (Medlogix) is handling decision point review/precertification and medical service review of this claim for Liberty Mutual Insurance Group, Inc. ("Liberty Mutual Insurance"), your patient's no-fault insurance carrier. Pursuant to N.J.A.C. 11:3-4, you are required to notify us of those services you intend to perform on the patient, as hereinafter explained. Liberty Mutual Insurance has contracted with Medlogix, LLC (Medlogix) for these purposes.

In accordance with N.J.A.C. 11:3-4.7(c) 3, a copy of all informational materials for policyholders, injured persons and providers approved by the New Jersey Department of Banking and Insurance, is available through our website at www.libertymutual.com and Medlogix, LLC website at www.Medlogix.com.

Please note, no decision point or precertification requirements shall apply within 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.

CARE PATHS/DECISION POINT REVIEW

As mentioned above, pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance (the "Department") has published standard courses of treatment, **Care Paths**, for soft tissue injuries of the neck and back, collectively referred to as the "Identified Injuries." N.J.A.C. 11:3-4 also establishes guidelines for the use of certain diagnostic tests. The Care Paths provide that treatment be evaluated at certain intervals called **Decision Points**. At Decision Points, you must provide us information about further treatment you intend to provide. This is called **Decision Point Review**. In addition, the administration of any test listed in N.J.A.C. 11:3-4.5 (b) 1-10 also requires Decision Point Review, regardless of the diagnosis. If you fail to submit requests for

Decision Point Reviews or fail to provide clinically supported findings that support the request, payment of your bills will result in a co-payment of 50% (in addition to any deductible or co-payment that applies under the policy) of the eligible charge medically necessary services. The **Care Paths** and accompanying rules are available on the Internet at the Department's website at www.nj.gov/dobi/aicrapg.htm or can be obtained by contacting Medlogix at 1 (877)258-CERT (2378).

MANDATORY PRECERTIFICATION

If your patient does not have an Identified Injury, you are required to obtain precertification of all the services listed below. If you fail to submit requests for the precertification of all the services listed below or fail to provide clinically supported findings that support the request, payment of your bills will result in a co-payment of 50% (in addition to any deductible or co-payment that applies under the policy) of the eligible charge for medically necessary services. You are encouraged to maintain communication with Medlogix on a regular basis as precertification requirements may change. Precertification is mandatory as to any of the following medical services once 10 days have elapsed since the accident:

- (a) non-emergency inpatient and outpatient hospital care
- (b) non-emergency surgical procedures
- (c) extended care rehabilitation facilities
- (d) outpatient care for soft tissue/disc injuries of the insured person's neck, back and related structures not included within the diagnoses covered by the Care Paths
- (e) physical, occupational, speech, cognitive or other restorative therapy or other body part manipulation, including massage therapy, except that provided for Identified Injuries in accordance with Decision Point Review
- (f) outpatient psychological/psychiatric testing and/or services
- (g) all pain management services except as provided for identified injuries in accordance with decision point review
- (h) home health care
- (i) non-emergency dental restoration
- (j) temporomandibular disorders; any oral facial syndrome
- (k) infusion therapy
- (l) Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of \$100.00.
- (m) Acupuncture
- (n) All treatment and testing related to balance disorders
- (o) Compound drugs and compounded prescriptions
- (p) Schedule II, III and IV Controlled Substances, as defined by the Drug Enforcement Administration (DEA), when prescribed in combination or succession for more than three (3) months

HOW TO SUBMIT DECISION POINT REVIEW/PRE-CERTIFICATION REQUESTS

Medlogix Hours of Operation – 8:00 AM to 5:00 PM EST Monday through Friday (excluding legal holidays)

In order for Medlogix to complete the review, you are required to submit all requests on the "Attending Physicians Treatment Plan" form.



A copy of this form can be found on the DOBI web site www.nj.gov/dobi/aicrapg.htm Medlogix's web site www.Medlogix.com or by contacting Medlogix at (877) 258-CERT (2378).

Please return this completed form, along with a copy of your most recent/appropriate progress notes and the results of any tests relative to the requested services to Medlogix via fax at (856) 910-2501 or mail to the following address: Medlogix, LLC, 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619, ATTN.: Precertification Department. Medlogix's phone number is (877) 258-CERT (2378).

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 your office by telephone, fax and/or confirmed in writing. If you are not notified within 3 business days, you may continue your test or course of treatment until such time as the final determination is communicated to you. Similarly, if an independent medical examination should be required, you may continue your tests or course of treatment until the results of the examination become available. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

Denials of decision point review and precertification 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.

To clarify the Medlogix processing time, the definition of days is as follows: "Days" means calendar days unless specifically designated as business days.

1. A calendar and business day both end at the time of the close of business hours 5:00 PM EST Monday through Friday (excluding legal holidays).
2. In computing any period of time designated as either calendar or business days, the day from which the designated period of time begins to run shall not be included. The last day of a period of time designated as calendar or business day is to be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday or legal holiday.
3. Example: Response to a properly submitted provider request is due back no later than 3 business days from the date Medlogix receives the submission. Medlogix receives an Attending Provider Treatment Plan Form by facsimile transmission dated 1:00 PM EST on Wednesday February 19, 2014. Day one of the 3-business day period is Thursday, February 20, 2014. Since the 3rd day would be Saturday, February 22, 2014, Medlogix's decision is due no later than close of business Monday, February 24, 2014.

INDEPENDENT MEDICAL EXAMS

If the need arises for Medlogix to utilize an independent medical exam during the decision point review/precertification process, the guidelines in accordance to 11:3-4.7(e) 1-7 will be followed. This includes but is not limited to: prior notification to the injured person or his or her designee, scheduling the exam within seven calendar days of the receipt of the attending physicians treatment plan form (unless the injured person agrees to extend the time period), having the exam conducted by a provider in the same discipline, scheduling the exam at a location reasonably convenient to the injured person, and providing notification of the decision within three (3) business days after attendance of the exam.

If the Injured Party/Examinee cannot attend a scheduled examination, Medlogix must be contacted at least three (3) business days prior to the scheduled examination by phone at (877) 258-CERT (2378), fax at (856) 910-2501, or in writing @ 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619, ATTN.: Precertification Department. The examinee is required to supply proper photo identification to the examining provider and, if the examinee is non-English speaking, then an English speaking interpreter must accompany the examinee (Interpreter fees and costs are not compensable or reimbursable). The examinee/designee must provide all pertinent medical records and diagnostic studies/tests available before, or at the time, of the examination. In addition, the examinee must cooperate fully with the examining physician and may be asked to bring specific prescribed durable medical equipment items to the examination. Failure to comply with any of the provisions as stated in this paragraph will be considered an unexcused absence to attend the scheduled exam.

If the injured person has more than one unexcused failure to attend the scheduled exam, notification will be immediately sent to the injured person or his or her designee, and all providers treating the injured person for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form. The notification will place the injured person on notice that all 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.

POSSIBLE OUTCOMES

The following are the possible outcomes of our review:

- (a) The requested service is certified.
- (b) If Medlogix receives information that, in their view, is insufficient to support the requested test or service, they will issue an administrative non-certification and will continue to non-cert the requested test or service until such time as they receive documentation sufficient to evaluate the request.



- (c) In the event Medlogix determines a change in the requested test or service is advisable (whether in frequency, duration, intensity or place of service or treatment), they will notify your office of the modified results
- (d) In the event Medlogix is unable to certify your request, your office will be notified of the results and a Medlogix Medical Director will be available through an internal reconsideration process to discuss the case with you. Medlogix may also request that the patient undergo an Independent Medical Examination. Any such exam will be scheduled in accordance with 11:3-4.7(e) 1-7 as stated in the Independent Medical Exams section above.

INTERNAL APPEAL PROCESS

All appeals must be initiated using the forms established by the New Jersey Department of Banking and Insurance. A copy of these forms can be found on the New Jersey Department of Banking and Insurance website, Medlogix's website (www.Medlogix.com), or by contacting Medlogix at (877) 258-CERT (2378).

There are two types of appeals, each with a separate and specific workflow, which will be considered:

Pre-Service Appeals: This is an appeal of the denial or modification of a decision point review or precertification request prior to the performance or issuance of the requested medical procedure, treatment, diagnostic test, durable medical equipment, and/or other service on the basis of medical necessity.

For the NEW JERSEY PIP PRE-SERVICE APPEAL FORM, the minimum required information (identified by form section number) is as follows: The key dates (sections 1-2), CLAIM INFORMATION (sections 3-5), PATIENT INFORMATION (sections 6-7 and 9-13), PROVIDER/FACILITY INFORMATION (sections 14-25), DOCUMENTS INCLUDED (section 29 indicated with asterisk), PRE-SERVICE APPEAL ISSUES (sections 30-31, and 32, 33, or 34), and the signature information (sections 35-36).

The New Jersey PIP Pre-Service Appeal Form and any supporting documentation shall be submitted by the provider to Medlogix via fax @ (856) 910-2501 or in writing @ 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

A pre-service appeal must be submitted no later than 30 days after receipt of a written denial or modification of requested services. Decisions on pre-service appeals shall be issued by Medlogix or the insurer to the provider who submitted the appeal no later than 14 days after receipt of the pre-service appeal form and any supporting documentation. If it is determined that new information submitted with the appeal requires the need of an expert report or addendum to an expert report (i.e.: Peer Review, Independent Medical Exam, Medical Director Review, etc.) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

Post-Service Appeals: This is an appeal subsequent to the performance or issuance of the services rendered and can include, but is not limited to, bill review issues, payment or non-payment.

For the NEW JERSEY PIP POST-SERVICE APPEAL FORM the minimum required information (identified by form section number) is as follows: The key dates (sections 1-2), CLAIM INFORMATION (sections 3-5), PATIENT INFORMATION (sections 6-7 and 9-13), PROVIDER/FACILITY INFORMATION (sections 14-25), DOCUMENTS INCLUDED (section 29 indicated with asterisk), POST-SERVICE APPEAL ISSUES (sections 30-31, 33 and/or 38 and 34-36 if completing section 38), and the signature information (sections 39-40).

The New Jersey PIP Post-Service Appeal Form and supporting documentation must be submitted to Liberty Mutual Insurance in writing at P.O. Box 515097, Los Angeles, CA 90051-5097.

A post-service appeal shall be submitted at least 45 days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in Superior Court. Decisions on post-service appeals shall be issued by the insurer or Medlogix to the party who submitted the appeal no later than 30 days after receipt of the appeal form and any supporting documentation. If it is determined that new information submitted with the appeal requires the need of an expert report or addendum to an expert report (i.e.: Professional Code Review, Medical Bill Audit Report, UCR Analytical Analysis, etc.) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

A provider cannot submit a Pre-Service Appeal and then a Post-Service Appeal on the same issue. The preapproval of treatment and reimbursement for that treatment are separate issues.

This Internal Appeal Process provides only one-level of appeal prior to submitting the dispute to alternate dispute resolution or litigation.

Failure to follow the Pre-Service and Post-Service appeal requirements will be considered an incomplete submission and will result in an administrative denial. This incomplete submission and administrative denial does not constitute acceptance of the appeal within the required timeframes for Pre-Service and Post-Service appeals.

Any provider who has accepted an assignment of benefits is required to follow the Internal Appeal Process as described and agrees to exhaust such appeals process prior to submitting any dispute through alternate dispute resolution or litigation. Failure to utilize the Internal Appeal Process as outlined will invalidate any assignment of benefits.

If a claimant, provider, or assignee retains counsel to represent them during the Internal Appeal Process, they do so strictly at their own expense. No reimbursement will be issued for counsel fees or any other costs, regardless of the outcome of the appeal.

ASSIGNMENTS OF BENEFITS

Pursuant to the terms of its insurance policies, Liberty Mutual Insurance will only accept its own form of Assignment of Benefits (Attached to this letter). This form of assignment must be signed by the insured and the Provider or an agent authorized to act on behalf of the Provider. By executing the Assignment of Benefits form or having it executed, the Provider agrees to be bound by terms of the assignment and other applicable terms, conditions and duties as set forth in the policy of insurance.

If the provider accepts assignment for payment of benefits, please be aware that the provider is required to hold harmless the insured and the

insurer for any reduction of benefits caused by the provider's failure to comply with the terms of this Decision Point Review/Precertification Plan



and the Policy's terms and conditions

Should Liberty Mutual file any action seeking relief under the New Jersey Insurance Fraud Prevention Act, N.J.S.A. 17:33A-1, et seq., N.J.S.A. 39:6A-13(G) or any cause of action alleging fraud or similar misconduct, the insured and/or the provider must agree to put any arbitration proceedings in abeyance until the legal action is resolved.

VOLUNTARY UTILIZATION PROGRAM

In accordance with N.J.A.C. 11:3-4.8(b) 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, H-reflex and nerve conduction velocity (NVC) tests performed together by the treating physician
4. Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of \$100.00
5. Services, equipment or accommodations provided by an ambulatory surgery facility
6. Prescription Drugs

When one of the above listed services, tests, prescription drugs or equipment is requested through the decision point review/precertification process, a detailed care plan evaluation letter containing the outcome of the review is sent to the injured person or his or her designee, and the requesting provider. In addition the notice will include how to acquire a list of available preferred provider networks to obtain the medically necessary services, tests, prescription drugs or equipment requested. In the case of Prescription Drugs, a pharmacy card will be issued that can be presented at numerous participating pharmacies. A list of these participating pharmacies will be made available at time of card issuance. In accordance with N.J.A.C.11:3-4.4(g), failure to use an approved network will result in an additional co-payment not to exceed 30% of the eligible charge.

In addition to securing a list of preferred provider networks through the process outlined in the paragraph above, visit Medlogix's website at www.Medlogix.com, contact Medlogix by phone at (877) 258-CERT (2378), via fax at (856) 910-2501, or in writing at 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

Should you have any questions or require any further information not available through the websites, don't hesitate to contact us or Medlogix.



Sincerely,

Adjusters First Name Last Name

Claims Resolution Specialist

ASSIGNMENT OF BENEFITS AGREEMENT & DISCLOSURE REQUIREMENTS

PLEASE READ CAREFULLY AS THIS IMPOSES DUTIES AND OBLIGATIONS UPON
THE PERSON AND THE ENTITY WHO SIGNS THIS AGREEMENT

I, (the patient) hereby assign my right to pursue a claim for reimbursement of Personal Injury Protection Benefits rendered by the medical provider who has signed this agreement (or designated an authorized representative to sign on his/her behalf) and his/her employees under the applicable insurance policy against Liberty Mutual Insurance Company. This assignment is expressly contingent upon the medical provider agreeing to the terms set forth in the Medical Provider Agreement below and I acknowledge that the medical provider's failure to honor the obligations set forth below render this assignment void. Nothing in this assignment authorizes the medical provider and/or its agents to pursue a claim for bodily injuries on my behalf. Furthermore, I authorize the release of medical records to the insurer and a photocopy of this document shall be considered as effective and valid as the original.

Signature of Patient: _____ Date:

Printed Name: _____ Date:

Medical Provider Agreement

I, (the medical provider or authorized agent for the medical provider), understand and agree to the terms of this Agreement on behalf of the Health Care Provider listed below and agree to abide by the following requirements and conditions:

1. I (individually and/or on behalf of my principal) agree to be personally bound by the terms and conditions of the Assignment of Benefits as contained in and made part of the applicable insurance policy, including the obligation to cooperate with investigations and limitations on arbitrations;
2. I agree to follow the Decision Point Review Plan and all requirements and conditions therein; and
3. I also agree to the following specific terms and conditions:

As a condition of this Assignment, upon commencement of treatment, I agree to cooperate with the insurer's investigation of this claim and any related claim, including, but not limited to, the following,

- a. Submitting to an examination under oath regarding the treatment provided and issues reasonably relevant to our claims decisions within thirty (30) days of any such request and subscribe to the same;
- b. Providing Liberty Mutual with copies of documents pertaining to the treatment provided and reasonably relevant to our claims decisions in your possession, in the possession of your agent(s) or which you can obtain using reasonable efforts which shall include but shall not be limited to those documents permitted by N.J.S.A. 39:6A-13;
- c. Allowing us to inspect original documents, objects or locations under your control and/or provide us with the authority to inspect such items if determined by us to be relevant to your claim which shall include but shall not be limited to those documents permitted by N.J.S.A. 39:6A-13. Inspections will be made during mutually convenient times but within 30 days of any such request;
- d. Allowing an inspection of the office(s) and location(s) where any professional services and or treatment or therapy were rendered at a mutually convenient time and date within thirty (30) days;

I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS AND CONDITIONS OF THIS AGREEMENT. I ALSO UNDERSTAND THE REQUIREMENTS MAY BE IN ADDITION TO OTHER CONDITIONS CONTAINED IN THE POLICY. I ALSO UNDERSTAND THAT I AM BOUND BY THESE TERMS, AS IS THE PRACTICE OR FACILITY WHERE THE PROFESSIONAL SERVICES AND/OR TREATMENT IS/WAS PROVIDED. I ALSO AM BOUND IF I HAVE AUTHORIZED SOMEONE TO SIGN THIS AGREEMENT ON MY BEHALF.

Signature: _____ Date:

Printed Name: _____ Date:

Professional/
Practice: _____ Date:

ATTENDING PROVIDER TREATMENT PLAN

EI INITIAL SUBMISSION

EI FOLLOW-UP SUBMISSION

DATE SUBMITTED

TYPE OR PRINT LEGIBLY				LAIM#:				PATENT INFORMATION						
1. PATENT INFORMATION		2. PATIENT'S ADDRESS		12 IS PATENT COMMON RELATED TO:		14. POLICY HOLDER INFORMATION		15. POLICY NUMBER		16. DATE OF ACCIDENT				
3. CITY		4. STATE		A EMPLOYMENT?		5. COMPANY		17. STATE		18. ZIP CODE				
5.2E CODE		S. TELEPHONE (4-Main Area)		B. ALTHOUGH ADDITIONAL?		18. TELEPHONE (Include Area Code)		19. ZIP CODE		20. OTHER ACCIDENT?				
7. PATIENT'S DATE OF BIRTH		9. EX		13. PATIENT UNABLE TO WORK?		21. POLICY NUMBER		22. DATE OF ACCIDENT		23. NFI				
S. NEARANCE COURANT		10. EX		14. PATIENT UNABLE TO WORK?		24. PENALTY		25. FACILITY		26. OFFICE NAME				
25. ADDRESS OF FIVE ADDRESS		27. CITY		25. STATE		26. ZIP CODE		31. TELEPHONE (Include Area Code)		32. FAX (Include Area Code)				
31. TELEPHONE (Include Area Code)		31. EMAIL ADDRESS		32. FAX (Include Area Code)		33. NFI DATE OF TX		34. DATE OF LAST VISIT		35. PATIENT'S CURRENT STATUS				
35. PATIENT'S CURRENT STATUS: HAS PATIENT EVER HAD ANY OF THE FOLLOWING CONDITIONS? O-HC-KMAR-IC THOSE APPLICABLE SELON. CHOTE-ALL BOXES CHECKED REQUIRE A BEEF DESCRIPTION OF SERVICE AND DATE PROVIDED TO SEPARATE ATTACHMENT?														
<input type="checkbox"/> MEDICATION <input type="checkbox"/> WOUND <input type="checkbox"/> BURN <input type="checkbox"/> X-RAY <input type="checkbox"/> DIAGNOSTIC TEST <input type="checkbox"/> ENSTEING CONDITIONS <input type="checkbox"/> ODDREINDTIE <input type="checkbox"/> DIRER														
37. APPLICABLE CARE PATH (Din mbel)														
<input type="checkbox"/> C.P1 <input type="checkbox"/> Q.2 <input type="checkbox"/> L.3 <input type="checkbox"/> CR4 <input type="checkbox"/> CPS <input checked="" type="checkbox"/> 1 C.P6														
PROPOSED COURSE OF TREATMENT				AS IT RELATES TO THIS ICA PROCEDURES, SERVICES OR SUPPLIES										
8. DATE OF REMEST				IE(Osh UL21:43 Oraart Jance)										
FROM	TO	0.	TO	EMM	ENT	SPINAL	W/M/VN	DIAGNOSE	PO	Y.P.	EOUENCY	FREOUENC	13JRATION	TOTAL LEA
UM	CC	YY	IV	A	Rental	1.4Claten	13.3lenI	PO	Y.P.	EOUENCY	FREOUENC	13JRATION	TOTAL LEA	

EI INCLUDE SUPPORTING DOCUMENTS:
 FR, 5. LID PREVENTION - NEW JERSEY WARNING
 ANT FERON VAL-1.1.31.VINSLY FLEE A STATEVENTDF CLAIM CONTANNG ANY FALSE OR HITLEADINT INFORM...M711E SUBJECT TO C'RILINAL AND CIVIL PENALTE T.
PROVIDER STATEMENT
 I HAVE PERSONALLY CONPLETED AND PRE...IEACED 11-19 FORM THE rdR14.IAT1CN IS TRUE AND GCRFCECT TOTHE 8EETOF MY KNOWLEDGEAND BELJEF.
 SIGNATURE OF PROVIDER _____ DATE _____