Personal Services Insurance Company
PO Box 1890
Blue Bell, PA 19422-0479
Ph: 1-800-727-6664 Fax: 1-610-832-1147

Date (##/##/####)

Physician Name
Street Address
City, State, Zip

Claimant:
Claim Number:
Medlogix ID #:
Date of Accident:
Insured:

Dear Provider:

This letter is to advise you that Medlogix LLC is handling decision point review/precertification, medical service review and medical fee schedule calculations of this claim for Personal Service Insurance Company (PSI), 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. PSI has contracted with Medlogix LLC (the "PIP Vendor") for these purposes.

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

Also included in the enclosed information is a "Conditional Assignment of Benefits" form for you and your patient to sign. Acceptance of assignment of benefits will be conditioned on Personal Service's receipt of a properly executed form, your acceptance of, and compliance with, the conditions stipulated therein. Please review the Conditional Assignment of Benefits carefully as it has been updated with additional conditions. These conditions apply to claims, such as this, with a date of loss and Personal Service policy renewal date on or after July 1, 2011. Providers who sign Personal Service's Conditional Assignment of Benefits for this claim agree to submit disputes as

defined in the Plan to an Internal **Appeal** process. Providers also agree to submit disputes not resolved by the Internal **Appeal** Process to the Personal Injury Protection Dispute Resolution process set forth in N.J.A.C. 11:3-5.

Providers who do not sign Personal Service's Conditional Assignment of Benefits are not eligible to submit PIP disputes to the Personal Injury Protection Dispute Resolution process.

A copy of the Conditional Assignment of Benefits is also available at Personal Service's web site, www.personalserviceins.com. If completed, please forward the Conditional Assignment of Benefits to the Personal Service claim office indicated above.

The Plan includes forums for dispute resolution: Internal **Appeal** and Personal Injury Protection Dispute Resolution set forth in N.J.A.C. 11:3-5. These forums are also described in the enclosed Plan.

Providers who retain counsel to assist them in the Internal Appeal process do so strictly at their own expense. Personal Service will not reimburse providers for their counsel fees or any other costs regardless of the outcome of the process.

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 for 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 @ 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 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 $75.00.

HOW TO SUBMIT DECISION POINT REVIEW/PRECERTIFICATION REQUESTS

Medlogix Hours of Operation – 7:00 AM to 7:00 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". 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 @ (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, 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619, ATTN.: Precertification Department. Its 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 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.

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 (7:00 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 6, 2013. Day one of the 3-buisness day period is Thursday, February 7, 2013. Since the 3rd day would be Saturday, February 9, 2013, Medlogix's decision is due no later than close of business Monday, February 11, 2013.

INDEPENDENT MEDICAL EXAMS

Separate and apart from a physical exam conducted pursuant to N.J.S.A. 39:6A-13(d), 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 business days after attendance of the exam.

If the injured person has two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to the injured person or his or her designee, and all providers known by to be 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 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.

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 feels 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.

MANDATORY INTERNAL APPEAL PROCESS

Under Personal Service Insurance Company's Conditional Assignment of Benefits, the provider shall be required to submit disputes to the Internal Appeal process before submitting the disputes to Personal Injury Protection Dispute Resolution under N.J.A.C. 11:3-5, et seq.

The Internal Appeal process is an attempt to resolve disputes directly between PSI and the provider.

Prior to making a request for alternate dispute resolution, all appeals must be initiated using the forms established by the NJ Department of Banking and Insurance. The minimum required information (identified by form section number) is as follows:
KEY DA TES (sections 1-2) CLAIM INFO (sections 3-5) PATIENT INFO (sections 6-7 and 9-13) PROVIDER/FACILITY INFO (sections 14-25) DOCUMENTS INCLUDED INFO (section 29 indicated with asterisk) PRE-SERVICE APPEALS ISSUES INFO (sections 30-31, and 32, 33, or 34) POST-SERVICE APPEALS ISSUES INFO (sections 30-31, 33 and/or 38 and 34-36 if completing section 38) PRE-SERVICE SIGNATURE INFO (sections 35-36) POST-SERVICE SIGNATURE INFO (sections 39-40).
Failure to follow these requirements will be considered an incomplete submission and will result in an administrative denial. This incomplete submission does not constitute acceptance within the required timeframes for Pre-service and Post-service appeals.

Failure to complete the Internal Appeals procedures as outlined in 11:3-4.7B on the forms established by the Department prior to filing arbitration or litigation will invalidate any assignment of benefits.

Completion of the internal appeal process means timely submission of an appeal and receipt of the response prior to filing for alternate dispute resolution. Except for emergency care as defined in N.J.A.C. 11:3-4.2, any treatment that is the subject of the appeal that is performed prior to the receipt by the provider of the appeal decision shall invalidate the assignment of benefits.

There are two types of appeals (with specific workflows) that can be considered:

Pre-service: 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, other service, and/or durable medical equipment on the grounds of medical necessity.

An appeal of a denial of a decision point review or precertification request must be made as pre-service appeal.

The 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 shall 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 the insurer or its designated vendor 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's determined that the new information submitted with the appeal requires the need of an expert report or addendum to an expert report (ie: 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: an appeal subsequent to the performance or issuance of the services and/or what should be reimbursed.

The Post-service appeal form and any supporting documentation shall be submitted by the provider to Medlogix via fax @ (856) 552-1999 or in writing @ 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

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 its designated vendor to the provider who submitted the appeal no later than 30 days after receipt of the appeal form and any supporting documentation. If it's determined that the new information submitted with the appeal requires the need of an expert report or addendum to an expert report (ie: 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.

The appeal process described above provides only one-level of appeal prior to submitting the dispute to alternate dispute resolution. A provider cannot submit a pre-service appeal and then a post-service appeal on the same issue. The preapproval of the treatment and the reimbursement for that treatment are separate issues. A provider can submit a pre-service appeal for the treatment and then a post-service appeal for the reimbursement for that treatment.

If a claimant or provider retains counsel to represent them during the Internal Appeal Procedures, 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.

PERSONAL INJURY PROTECTION DISPUTE RESOLUTION

A PIP dispute, as defined by N.J.A.C. 11:3-5, may be submitted to Personal Injury Protection (PIP) Dispute Resolution in accordance with the Personal Service Insurance Company policy. PIP Dispute Resolution shall be conducted in accordance with the procedures set forth in N.J.A.C. 11:3-5, including any amendments. The final determination made by the dispute resolution professional shall be binding on the parties, but subject to vacation, modification or correction by the Superior Court in an action filed pursuant to N.J.S.A 2A:23A-13 for review of the award.

Under PSI's Conditional Assignment of Benefits, after exhausting the Internal Appeal process, a provider must submit any PIP dispute, as defined by N.J.A.C. 11:3-5, to PIP Dispute Resolution in accordance with this Plan.

ASSIGNMENTS OF BENEFITS

Please also note that, if you accept an assignment of benefits from the patient, you are required to hold the insured harmless from any reduction in benefits caused by a failure on your part to follow the decision point review/pre-certification process. All assignments are subject to all requirements, duties and conditions of the insurer's pre-certification plan, patient's/insured's policy, including, but not limited to, pre-certification, Decision Point Reviews, *internal appeals*, exclusions, deductibles and copayments.

As a condition of the assignment of benefits, the treating medical provider or provider of service benefits agrees to comply with all the procedures of the Plan. The provider also agrees to initiate all Precertification and Decision Point Review requests as required by the Plan. In the event the provider fails to comply with the conditions of the Plan, and such failure results in the imposition of a co-payment penalty, the provider will hold the patient harmless for such co-payment penalty insofar as the provider will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty. Additional conditions that also apply to the provider include:

a) Submission of disputes as defined in the Plan to the Internal Appeal Process set forth therein. After final determination, submission of disputes not resolved by the Internal Appeal process may be submitted to the Personal Injury Protection Dispute Resolution

process set forth in N.J.A.C. 11:3-5.

b) Submission of medical records with clinically supported findings to support the diagnosis, causal relationship to the accident and care plan.

PSI's Conditional Assignment of Benefits is the only valid assignment of benefits. The assignee agrees that PSI has the right to reject, terminate or revoke the PSI Conditional Assignment of Benefits. An assignment of benefits may require PSI's written consent.

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 $75.00
5. Services, equipment or accommodations provided by an ambulatory surgery facility

When one of the above listed services, tests 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 or equipment requested. 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 percent 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 @ www.medlogix.com, contact Medlogix by phone @ (877) 258- CERT (2378), via fax @ (856) 910-2501, or in writing @ 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,

Personal Service Insurance Company
PO Box 1890
Blue Bell, PA 19422-0479