Filing at a Glance

Companies:	American Modern Home Insurance Company American Family Home Insurance Company American Modern Property and Casualty Insurance Company
Product Name:	Auto
State:	New Jersey
TOI:	35.0 Interline Filings
Sub-TOI:	35.0000 Personal/Commercial Interline Filings
Filing Type:	Form
Date Submitted:	11/20/2020
SERFF Tr Num:	AMMH-132617290
SERFF Status:	Closed-Approved
State Tr Num:	20-2419
State Status:	Approved
Co Tr Num:	20201120-01
Co Status:	
Effective Date Requested (New):	03/01/2021
Effective Date Requested (Renewal):	
Author(s):	Missy Deller, Jayme Gray
Reviewer(s):	Harry Davenport (primary)
Disposition Date:	01/27/2021
Disposition Status:	Approved
Effective Date (New):	03/01/2021
Effective Date (Renewal):	

General Information

Project Name: DPR filing
Project Number: 20201120-01
Reference Organization:
Reference Title:
Filing Status Changed: 01/27/2021
State Status Changed: 01/27/2021
Created By: Missy Deller
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Not Filed
Domicile Status Comments:
Reference Number:
Advisory Org. Circular:
Company Status Changed:
Deemer Date:
Submitted By: Missy Deller

Filing Description:
This is a "me-too" Decision Point Review Plan (DPR) form filing to use with New Jersey Personal Injury Protection Claims.

Company and Contact

Filing Contact Information

Melissa Deller, Filing Analyst
7000 Midland Blvd.
Amelia, OH 45102

mdeller@amig.com
800-759-9008 [Phone] 5871 [Ext]
513-947-4655 [FAX]

Filing Company Information

American Family Home Insurance Company
1301 Riverplace Blvd, Ste 1300
Jacksonville, FL 32207
(800) 759-9008 ext. [Phone]

CoCode: 23450
Group Code: 361
Group Name: Munich Re
FEIN Number: 31-0711074

State of Domicile: Florida
Company Type: Property and Casualty
State ID Number:

American Modern Home Insurance Company
7000 Midland Blvd.
Amelia, OH 45102
(800) 759-9008 ext. [Phone]

CoCode: 23469
Group Code: 361
Group Name: Munich Re
FEIN Number: 31-0715697

State of Domicile: Ohio
Company Type: Property and Casualty
State ID Number:

American Modern Property and Casualty Insurance Company
7000 Midland Boulevard
Amelia, OH 45102
(800) 759-9008 ext. [Phone]

CoCode: 42722
Group Code: 361
Group Name: Munich Re
FEIN Number: 43-1262602

State of Domicile: Ohio
Company Type: Property and Casualty
State ID Number:

State: *New Jersey* **First Filing Company:** *American Modern Home Insurance Company, ...*
TOI/Sub-TOI: *35.0 Interline Filings/35.0000 Personal/Commercial Interline Filings*
Product Name: *Auto*
Project Name/Number: *DPR filing/20201120-01*

Filing Fees

State Fees

Fee Required? No

Retaliatory? No

Fee Explanation:

SERFF Tracking #:	*AMMH-132617290*	***State Tracking #:***	*20-2419*	***Company Tracking #:***	*20201120-01*

State:	*New Jersey*	***First Filing Company:***	*American Modern Home Insurance Company, ...*
TOI/Sub-TOI:	*35.0 Interline Filings/35.0000 Personal/Commercial Interline Filings*		
Product Name:	*Auto*		
Project Name/Number:	*DPR filing/20201120-01*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Harry Davenport	01/27/2021	01/27/2021

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Harry Davenport	01/15/2021	01/15/2021

Response Letters

Responded By	Created On	Date Submitted
Missy Deller	01/22/2021	01/22/2021

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Status update	Note To Reviewer	Missy Deller	01/13/2021	01/13/2021

SERFF Tracking #:	*AMMH-132617290*	***State Tracking #:***	*20-2419*	***Company Tracking #:***	*20201120-01*

State:	*New Jersey*	***First Filing Company:***	*American Modern Home Insurance Company, ...*
TOI/Sub-TOI:	*35.0 Interline Filings/35.0000 Personal/Commercial Interline Filings*		
Product Name:	*Auto*		
Project Name/Number:	*DPR filing/20201120-01*		

Disposition

Disposition Date: 01/27/2021
Effective Date (New): 03/01/2021
Effective Date (Renewal):
- Effective Date (New) changed from 02/01/2021 to 03/01/2021 by Davenport, Harry on 02/03/2021.

Status: Approved

Comment: Commissioner Marlene Caride has approved the filing. The filing will become effective 2/1/2021. Should this effective date be inconvenient for your needs, please contact us immediately.

Rate data does NOT apply to filing.

Overall Rate Information for Multiple Company Filings	
Overall Percentage Rate Indicated For This Filing	0.000%
Overall Percentage Rate Impact For This Filing	0.000%
Effect of Rate Filing-Written Premium Change For This Program	$0
Effect of Rate Filing - Number of Policyholders Affected	0

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Cover Letter		Yes
Supporting Document	Explanatory Memorandum		Yes
Supporting Document	Side by Side Comparison		Yes
Supporting Document (revised)	Supporting Documents		Yes
Supporting Document	Supporting Documents		Yes
Supporting Document	Contract		No

State: New Jersey **First Filing Company:** American Modern Home Insurance Company, ...
TOI/Sub-TOI: 35.0 Interline Filings/35.0000 Personal/Commercial Interline Filings
Product Name: Auto
Project Name/Number: DPR filing/20201120-01

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	01/15/2021
Submitted Date	01/15/2021
Respond By Date	01/22/2021

Dear Melissa Deller,

Introduction:

For the review of the referenced filing we will require answers to the following questions/concerns.

Objection 1

Comments: Please confirm that you are currently not imposing an copayments/penalties pursuant to N.J.A.C. 11:3-4. If not, please explain.

Objection 2

Comments: Is the proposed Decision Point Review/Precertification Plan filing applicable to both Personal and Commercial Auto or Personal Auto only.

Objection 3

Comments: Will the new Decision Point Review Plan apply to new and existing claims or to new claims only?

If the Plan applies to both new and existing claims, how many current PIP claims, as well as re-opened claims would be impacted by the new Decision Point Review/Precertification Plan?

Objection 4

- Supporting Documents (Supporting Document)

Comments: Please populate the Insurer name and address fields under Q&A Brochure and Dear Provider Letter documents.

Conclusion:

Sincerely,
Harry Davenport

SERFF Tracking #:	AMMH-132617290	**State Tracking #:**	20-2419	**Company Tracking #:**	20201120-01

State:	New Jersey	**First Filing Company:**	American Modern Home Insurance Company, ...
TOI/Sub-TOI:	35.0 Interline Filings/35.0000 Personal/Commercial Interline Filings		
Product Name:	Auto		
Project Name/Number:	DPR filing/20201120-01		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	01/22/2021
Submitted Date	01/22/2021

Dear Harry Davenport,

Introduction:

This is in response to the objection dated 1/15/2021.

Response 1

Comments:

American Modern does not have a NJ Decision Point Review Plan in place. As such, we are not currently imposing precertification penalties to NJ PIP Claims.

Related Objection 1

Comments: Please confirm that you are currently not imposing an copayments/penalties pursuant to N.J.A.C. 11:3-4. If not, please explain.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments:

Yes the proposed Decision Point Review Plan filing is applicable to both Personal and Commercial auto.

Related Objection 2

Comments: Is the proposed Decision Point Review/Precertification Plan filing applicable to both Personal and Commercial Auto or Personal Auto only.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 3

Comments:

The new Decision Point Review Plan will apply to new claims only.

Related Objection 3

Comments: Will the new Decision Point Review Plan apply to new and existing claims or to new claims only?

If the Plan applies to both new and existing claims, how many current PIP claims, as well as re-opened claims would be impacted by the new Decision Point Review/Precertification Plan?

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 4

Comments:

Based on our phone conversation today, I've updated the Q & A Brochure's the last page (7) showing the company address that will be listed for each company. The company name will populate with the appropriate company based on the underwriting company. The Dear Provider letter will populate the appropriate company letterhead based on the appropriate underwriting company. Please let me know if you need additional information.

Related Objection 4

Applies To:

- Supporting Documents (Supporting Document)

Comments: Please populate the Insurer name and address fields under Q&A Brochure and Dear Provider Letter documents.

Changed Items:

SERFF Tracking #:	*AMMH-132617290*	***State Tracking #:***	*20-2419*	***Company Tracking #:***	*20201120-01*

State:	*New Jersey*	***First Filing Company:***	*American Modern Home Insurance Company, ...*
TOI/Sub-TOI:	*35.0 Interline Filings/35.0000 Personal/Commercial Interline Filings*		
Product Name:	*Auto*		
Project Name/Number:	*DPR filing/20201120-01*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Supporting Documents
Comments:	Dear Provider Letter, Narrative Plan Document, and QA Brochure.
Attachment(s):	Medlogix LLC 18-0255 Initial Dear Provider Ltr.pdf Medlogix LLC 18-0255 Initial Narrative Plan Document.pdf Medlogix LLC 18-0255 Initial QA Brochure with address.pdf
Previous Version	
Satisfied - Item:	*Supporting Documents*
Comments:	*Dear Provider Letter, Narrative Plan Document, and QA Brochure.*
Attachment(s):	*Medlogix LLC 18-0255 Initial Dear Provider Ltr.pdf* *Medlogix LLC 18-0255 Initial Narrative Plan Document.pdf* *Medlogix LLC 18-0255 Initial QA Brochure.pdf*

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Thank you for your time and consideration with this filing.

Sincerely,

Missy Deller

State: *New Jersey* **First Filing Company:** *American Modern Home Insurance Company, ...*
TOI/Sub-TOI: *35.0 Interline Filings/35.0000 Personal/Commercial Interline Filings*
Product Name: *Auto*
Project Name/Number: *DPR filing/20201120-01*

Note To Reviewer

Created By:

Missy Deller on 01/13/2021 08:45 AM

Last Edited By:

Missy Deller

Submitted On:

01/13/2021 08:45 AM

Subject:

Status update

Comments:

Could I please get a status update on this filing. Thank you so much for your time and consideration.

State: *New Jersey* ***First Filing Company:*** *American Modern Home Insurance Company, ...*
TOI/Sub-TOI: *35.0 Interline Filings/35.0000 Personal/Commercial Interline Filings*
Product Name: *Auto*
Project Name/Number: *DPR filing/20201120-01*

Post Submission Update Request Processed On 02/03/2021

Status: Allowed
Created By: Missy Deller
Processed By: Harry Davenport
Comments:

General Information:

Field Name	Requested Change	Prior Value
Effective Date Requested (New)	03/01/2021	02/01/2021

SERFF Tracking #:	*AMMH-132617290*	***State Tracking #:***	*20-2419*	***Company Tracking #:***	*20201120-01*

State:	*New Jersey*	***First Filing Company:***	*American Modern Home Insurance Company, ...*
TOI/Sub-TOI:	*35.0 Interline Filings/35.0000 Personal/Commercial Interline Filings*		
Product Name:	*Auto*		
Project Name/Number:	*DPR filing/20201120-01*		

Supporting Document Schedules

Satisfied - Item:	Cover Letter
Comments:	
Attachment(s):	NJ DPR Cover letter.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Explanatory Memorandum
Comments:	
Attachment(s):	Filing Memorandum.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Side by Side Comparison
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Supporting Documents
Comments:	Dear Provider Letter, Narrative Plan Document, and QA Brochure.
Attachment(s):	Medlogix LLC 18-0255 Initial Dear Provider Ltr.pdf Medlogix LLC 18-0255 Initial Narrative Plan Document.pdf Medlogix LLC 18-0255 Initial QA Brochure with address.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Contract
Comments:	
Attachment(s):	AMIG-Medlogix_MSA-SOW1_October 2020 - signed.pdf
Item Status:	
Status Date:	

SERFF Tracking #:	*AMMH-132617290*	***State Tracking #:***	*20-2419*	***Company Tracking #:***	*20201120-01*

State:	*New Jersey*	***First Filing Company:***	*American Modern Home Insurance Company, ...*
TOI/Sub-TOI:	*35.0 Interline Filings/35.0000 Personal/Commercial Interline Filings*		
Product Name:	*Auto*		
Project Name/Number:	*DPR filing/20201120-01*		

Attachment AMIG-Medlogix_MSA-SOW1_October 2020 - signed.pdf could not be reproduced here for the following reason: Unknown encryption type R = 6

7000 Midland Boulevard
Amelia, OH 45102-2646
AMIG.COM

November 20, 2020

New Jersey Department of Banking and Insurance
Office of Property and Casualty
PO Box 325
Trenton, NJ 08625-0325

Dear Reviewer,

American Modern Insurance Group has selected Medlogix, LLC, to handle/process decision point review/pre-certification requests and provider bill re-pricing.

Attached are the following documents to complete a “me too” filing of the Medlogix, LLC, Decision Point Review/Pre-certification Plan (Department File No. 18-0255) with an effective date of February 1, 2021.

- Question & Answer Brochure
- Narrative Plan
- Dear Provider Letter

Thank you for your time and attention in this matter. If you have any questions regarding this submission, please contact me.

Sincerely,

Melissa Deller

Regulatory Compliance Manager
mdeller@amig.com
1-800-759-9008 ext. 5871

Filing Memorandum
New Jersey
Decision Point Review filing

American Family Home Insurance Company, American Modern Home Insurance Company, and American Modern Property and Casualty Insurance Company, are filing this “me too” filing of the Medlogix, LLC, Decision Point Review/Pre-certification Plan (Department File No. 18-0255) to be effective February 1, 2021.

Insurer Name
Address
City, State, Zip
Phone Fax

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 (Medlogix)** is handling decision point review/pre-certification, medical service review and medical fee schedule calculations of this claim for Insurer Name, 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. Insurer Name has contracted with **Medlogix** (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 **Medlogix website @ www.medlogix.com.**

Please note, no decision point or pre-certification 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 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 PRE-CERTIFICATION

If your patient does not have an Identified Injury, you are required to obtain pre-certification of all the services listed below. If you fail to submit requests for the pre-certification 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 pre-certification requirements may change. Pre-certification 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.
(m) Acupuncture
(n) Compound Drugs and compounded prescriptions
(o) 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 – 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" 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** @ (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.: Pre-Certification 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 pre-certification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist.

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

If the need arises for **Medlogix** to utilize an independent medical exam during the decision point review/pre-certification 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 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.

INTERNAL APPEAL PROCESS

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 DATES (sections 1-2) CLAIM INFO (sections 3-5) PATIENT INFO (sections 6-7 and 913) 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 utilize 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.

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.

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) 910-2501 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.

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, exclusions, deductibles and co-payments.

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
6. Prescription Drugs

When one of the above listed services, tests, prescription drugs or equipment is requested through the decision point review/pre-certification 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 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,

Insurer Name
Address
City, State, Zip

Narrative Description of the Generic Decision Point Review/Pre-certification Plan

Medlogix Hours of Operation – 7:00 AM to 7:00 PM EST Monday through Friday (excluding legal holidays)

At the time of policy issuance and renewal a Question and Answer brochure (see example under correspondence section) will be distributed to the policy holder. This document will outline all key elements/requirements/responsibilities of the plan as required in N.J.A.C. 11:3-4.7(d)1-9. This information will also be made available on the World Wide Web @ the insurer's site and **www.medlogix.com**.

When an injured person notifies the insurer of a claim, the insurer will send out a PIP packet including but not limited to the Question and Answer brochure and a Dear Provider letter (see example under correspondence section) to bring along with any upcoming visits for medical services, tests or equipment.

As required under N.J.A.C. 11:3-4.4(f), the insured, injured person or treating provider may notify the insurer and/or **Medlogix** of the health care providers supplying treatment, diagnostic tests or durable medical equipment. All identified health care providers will receive the Dear Provider letter outlining the duties and responsibilities of all involved parties and the consequences for failure to comply.

Upon receipt of the Attending Physicians Treatment Plan form and related supporting documents, **Medlogix** will complete a medical necessity review within three business days.

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.

Medlogix will communicate the findings (administrative non-certification, approval, modification or denial) to the requesting health care provider and injured person or his or her designee on a Care Plan Evaluation letter (see example under correspondence section).

Denials of decision point review and pre-certification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist.

If the need arises for **Medlogix** to utilize an independent medical exam during the decision point review/pre-certification 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 (unless the injured person agrees to extend the time period) through a detailed scheduling letter sent to the injured person or his or her designee(see example under correspondence section), 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 on a Care Plan Evaluation letter.

If the injured person has more than one unexcused failures to attend the scheduled exam, notification will be immediately sent (on a Care Plan Evaluation letter) 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 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.

If a treating health care provider fails to submit a request for decision point review/pre-certification or fails to provide clinically supported findings that support the request as outlined in the plan, payment of medically necessary services will result in co-payment of 50% (in addition to any deductible or co-payment that applies under the policy) of the eligible charge.

If **Medlogix** fails to respond to a request within three business days, the treating health care provider may continue with the course of care until **Medlogix** communicates its findings.

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 DATES (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 utilize 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.

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.

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) 910-2501 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.

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
6. Prescription Drugs

When one of the above listed services, tests, equipment, or prescription drugs is requested through the decision point review/pre-certification 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, equipment, or prescription drugs 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 the 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 a co-payment of 30 % (in addition to any deductible or co-payment that applies under the policy) of the eligible charge.

In addition to securing a list of preferred provider networks through the process outlined in the paragraph above, the injured person or his or her designee, and the requesting provider can 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.

Upon receipt of a Providers bill (HICFA-1500, UB-92, etc...), **Medlogix** will utilize its repricing software (Medlogix®) to adjudicate against any submitted requests, and produce a detailed explanation of benefits outlining a suggested reimbursement.

INTRODUCTION BROCHURE

At carrier, we understand that when you purchase an automobile insurance policy, you are buying protection and peace of mind in the event you are injured in an accident. It is, therefore, important to you that carrier provide you first rate claims service. Our goal is to process claims for medically necessary treatment and testing quickly and fairly.

This brochure explains how your medical claims will be handled, including the Decision Point Review/Pre-certification requirements which you and your medical provider must follow in order to receive the maximum benefits provided by your policy. Please read this brochure carefully. If you have any questions, please call your Claim Representative at

DECISION POINT REVIEW AND PRE-CERTIFICATION REQUIREMENTS

Please note: Under the provisions of your policy and applicable New Jersey regulations, Decision Point Reviews and/or Pre-certification of specified medical treatment and testing is required in order for medically necessary expenses to be fully reimbursable under the terms of your policy. The following questions and answers only provide an overview of Decision Point Reviews and Pre-certification requirements. You should read your policy for the actual Pre-certification requirements as well as other policy terms and conditions.

Treatment in the first 10 days after an accident and emergency care does not require Decision Point Review or Pre-certification. However, for benefits to be paid in full, the treatment must be medically necessary. This is true in all events.

Question: What is a Decision Point Review?

Answer: 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". These Care Paths provide your health care provider with general guidelines for treatment and diagnostic testing as to these injuries. In addition the Care Paths require that treatment be evaluated at certain intervals called **Decision Points**. At Decision Points, your health care provider must provide us information about any further treatment or test required. This is called **Decision Point Review.** During the Decision Point Review process, all services requested are evaluated by medical professionals to insure the level of care you are receiving is medically necessary for your injuries. This does not mean that you are required to obtain our approval before consulting your medical provider for your injuries. However, it does mean that your medical provider is required to follow the Decision Point Review requirements in order for you to receive maximum reimbursement under the policy. 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. 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).

Question: What is Pre-certification?

Answer: Pre-certification is a medical review process for the specific services, test or equipment listed below in (a)-(l). During this process all services, test or equipment requested are evaluated by medical professionals to insure the level of services, tests or equipment you are receiving is medically necessary for your injuries. This does not mean that you are required to obtain our approval before consulting your medical provider for your injuries. However, it does mean that your medical provider is required to follow the Pre-certification requirements in order for you to receive maximum reimbursement under the policy.

(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.
(m) Acupuncture
(n) Compound Drugs and compounded prescriptions
(o) 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

Question: What do I need to do to comply with the Decision Point Review and Pre-certification requirements in my policy?

Answer: Just provide us with the name(s) of your medical providers. We will then contact them to explain the entire process. You should also give your medical provider a copy of the "*Dear Provider Letter*" included with this brochure.

Question: What are the Vendors hours of operation?

Answer: **Medlogix** Hours of Operation – 7:00 AM to 7:00 PM EST Monday through Friday (excluding legal holidays)

Question: How does the Decision Point Review/Pre-certification Process Work?

Answer: In order for **Medlogix** to complete the review, your health care provider is 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** @ (877) 258-CERT (2378).

The health care provider should submit the completed form, along with a copy of your their 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.: Pre-Certification 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 both you and your health care provider by telephone, fax and/or confirmed in writing. If your health care provider is not notified within 3 business days, they may continue your test or course of treatment until such time as the final determination is communicated to them. Similarly, if an independent medical examination should be required, they may continue your tests or course of treatment until the results of the examination become available.

Denials of decision point review and pre-certification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist.

Question: What is the definition of days?

Answer: 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

Question: What are the requirements and consequences if I am requested to attend an Independent Medical Exam?

Answer: If the need arises for **Medlogix** to utilize an independent medical exam during the decision point review/pre-certification 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 examining provider prepares a written report concerning the examination, you or your designee shall be entitled to a copy upon written request.

If you have two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to you, and all health care providers treating you for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form. The notification will place you on notice that all future treatment, diagnostic testing or durable medical equipment required for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form will not be reimbursable as a consequence for failure to comply with the plan.

INTERNAL APPEAL PROCESS

Question: Can my health care provider appeal a Pre-Service or Post-Service denial?

Answer: Yes, 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 DATES (sections 1-2) CLAIM INFO (sections 3-5) PATIENT INFO (sections 6-7 and 913) 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 utilize 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.

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.

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) 910-2501 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.

VOLUNTARY UTILIZATION PROGRAM

Question: Does the plan provide voluntary networks for certain services, tests or equipment?

Answer: In accordance with the regulations, the plan includes a voluntary utilization program for:

1. Magnetic Resonance Imagery
2. Computer Assisted Tomography
3. The electro diagnostic tests listed in N.J.A.C. 11:3-4.5(b)1 through 3 except for needle EMGs, 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
6. Prescription Drugs

Question: How do I gain access to one of these networks?

Answer: When one of the above listed services, tests, prescription drugs or equipment is requested through the decision point review/pre-certification process, a detailed care plan evaluation letter containing the outcome of the review is sent to you, and the requesting health care provider. The notice will include how to acquire a list of available preferred provider networks, with phone numbers and addresses, 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 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.

PENALTY CO-PAYMENTS

Question: Why would payment of my bills for health care services, tests and durable medical equipment be subject to additional co-pay, and how much is it?

Answer: If you're health care provider does not comply with the decision point review/pre-certification previsions of the plan, including failure to submit a request for decision point review/pre-

certification or failure to provide clinically supported findings that support the request, payment of those services rendered will result in a co-payment of 50% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment and tests and equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

If you do not utilize a network provider/facility to obtain those services, tests, prescription drugs or equipment listed in the voluntary utilization review program section, payment for those services rendered will result in a co-payment of 30% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment, tests and equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

ASSIGNMENT OF BENEFITS

Question: Can I assign my benefits?

Answer: Yes, but only to a provider of service benefits. Please read the Assignment of PIP Benefits section in your policy carefully. All assignments are subject to all requirements, duties and conditions of the policy, including, but not limited to, Pre-certification, Decision Point Reviews, exclusions, deductibles and co-payments.

NO COVERAGE IS PROVIDED BY THIS BROCHURE OR THE QUESTIONS AND ANSWERS CONTAINED IN IT. THIS BROCHURE DOES NOT REPLACE ANY OF THE PROVISIONS OF YOUR POLICY. YOU SHOULD READ YOUR POLICY CAREFULLY FOR COMPLETE INFORMATION AS TO THE TERMS OF YOUR COVERAGE. IF THERE IS ANY CONFLICT BETWEEN THE POLICY AND THIS SUMMARY, THE PROVISIONS OF THE POLICY SHALL PREVAIL.

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

Name
PO Box 5323
Cincinnati, OH 45201

SERFF Tracking #:	*AMMH-132617290*	***State Tracking #:***	*20-2419*	***Company Tracking #:***	*20201120-01*

State:	*New Jersey*	***First Filing Company:***	*American Modern Home Insurance Company, ...*
TOI/Sub-TOI:	*35.0 Interline Filings/35.0000 Personal/Commercial Interline Filings*		
Product Name:	*Auto*		
Project Name/Number:	*DPR filing/20201120-01*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
11/20/2020		Supporting Document	Supporting Documents	01/22/2021	Medlogix LLC 18-0255 Initial Dear Provider Ltr.pdf Medlogix LLC 18-0255 Initial Narrative Plan Document.pdf Medlogix LLC 18-0255 Initial QA Brochure.pdf (Superceded)

INTRODUCTION BROCHURE

At carrier, we understand that when you purchase an automobile insurance policy, you are buying protection and peace of mind in the event you are injured in an accident. It is, therefore, important to you that carrier provide you first rate claims service. Our goal is to process claims for medically necessary treatment and testing quickly and fairly.

This brochure explains how your medical claims will be handled, including the Decision Point Review/Pre-certification requirements which you and your medical provider must follow in order to receive the maximum benefits provided by your policy. Please read this brochure carefully. If you have any questions, please call your Claim Representative at

DECISION POINT REVIEW AND PRE-CERTIFICATION REQUIREMENTS

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Treatment in the first 10 days after an accident and emergency care does not require Decision Point Review or Pre-certification. However, for benefits to be paid in full, the treatment must be medically necessary. This is true in all events.

Question: What is a Decision Point Review?

Answer: 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". These Care Paths provide your health care provider with general guidelines for treatment and diagnostic testing as to these injuries. In addition the Care Paths require that treatment be evaluated at certain intervals called **Decision Points**. At Decision Points, your health care provider must provide us information about any further treatment or test required. This is called **Decision Point Review.** During the Decision Point Review process, all services requested are evaluated by medical professionals to insure the level of care you are receiving is medically necessary for your injuries. This does not mean that you are required to obtain our approval before consulting your medical provider for your injuries. However, it does mean that your medical provider is required to follow the Decision Point Review requirements in order for you to receive maximum reimbursement under the policy. 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. 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).

Question: What is Pre-certification?

Answer: Pre-certification is a medical review process for the specific services, test or equipment listed below in (a)-(l). During this process all services, test or equipment requested are evaluated by medical professionals to insure the level of services, tests or equipment you are receiving is medically necessary for your injuries. This does not mean that you are required to obtain our approval before consulting your medical provider for your injuries. However, it does mean that your medical provider is required to follow the Pre-certification requirements in order for you to receive maximum reimbursement under the policy.

(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.
(m) Acupuncture
(n) Compound Drugs and compounded prescriptions
(o) 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

Question: What do I need to do to comply with the Decision Point Review and Pre-certification requirements in my policy?

Answer: Just provide us with the name(s) of your medical providers. We will then contact them to explain the entire process. You should also give your medical provider a copy of the "*Dear Provider Letter*" included with this brochure.

Question: What are the Vendors hours of operation?

Answer: **Medlogix** Hours of Operation – 7:00 AM to 7:00 PM EST Monday through Friday (excluding legal holidays)

Question: How does the Decision Point Review/Pre-certification Process Work?

Answer: In order for **Medlogix** to complete the review, your health care provider is 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** @ (877) 258-CERT (2378).

The health care provider should submit the completed form, along with a copy of your their 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.: Pre-Certification 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 both you and your health care provider by telephone, fax and/or confirmed in writing. If your health care provider is not notified within 3 business days, they may continue your test or course of treatment until such time as the final determination is communicated to them. Similarly, if an independent medical examination should be required, they may continue your tests or course of treatment until the results of the examination become available.

Denials of decision point review and pre-certification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist.

Question: What is the definition of days?

Answer: 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

Question: What are the requirements and consequences if I am requested to attend an Independent Medical Exam?

Answer: If the need arises for **Medlogix** to utilize an independent medical exam during the decision point review/pre-certification 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 examining provider prepares a written report concerning the examination, you or your designee shall be entitled to a copy upon written request.

If you have two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to you, and all health care providers treating you for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form. The notification will place you on notice that all future treatment, diagnostic testing or durable medical equipment required for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form will not be reimbursable as a consequence for failure to comply with the plan.

INTERNAL APPEAL PROCESS

Question: Can my health care provider appeal a Pre-Service or Post-Service denial?

Answer: Yes, 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 DATES (sections 1-2) CLAIM INFO (sections 3-5) PATIENT INFO (sections 6-7 and 913) 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 utilize 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.

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.

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) 910-2501 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.

VOLUNTARY UTILIZATION PROGRAM

Question: Does the plan provide voluntary networks for certain services, tests or equipment?

Answer: In accordance with the regulations, the plan includes a voluntary utilization program for:

1. Magnetic Resonance Imagery
2. Computer Assisted Tomography
3. The electro diagnostic tests listed in N.J.A.C. 11:3-4.5(b)1 through 3 except for needle EMGs, 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
6. Prescription Drugs

Question: How do I gain access to one of these networks?

Answer: When one of the above listed services, tests, prescription drugs or equipment is requested through the decision point review/pre-certification process, a detailed care plan evaluation letter containing the outcome of the review is sent to you, and the requesting health care provider. The notice will include how to acquire a list of available preferred provider networks, with phone numbers and addresses, 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 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.

PENALTY CO-PAYMENTS

Question: Why would payment of my bills for health care services, tests and durable medical equipment be subject to additional co-pay, and how much is it?

Answer: If you're health care provider does not comply with the decision point review/pre-certification previsions of the plan, including failure to submit a request for decision point review/pre-

certification or failure to provide clinically supported findings that support the request, payment of those services rendered will result in a co-payment of 50% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment and tests and equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

If you do not utilize a network provider/facility to obtain those services, tests, prescription drugs or equipment listed in the voluntary utilization review program section, payment for those services rendered will result in a co-payment of 30% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment, tests and equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

ASSIGNMENT OF BENEFITS

Question: Can I assign my benefits?

Answer: Yes, but only to a provider of service benefits. Please read the Assignment of PIP Benefits section in your policy carefully. All assignments are subject to all requirements, duties and conditions of the policy, including, but not limited to, Pre-certification, Decision Point Reviews, exclusions, deductibles and co-payments.

NO COVERAGE IS PROVIDED BY THIS BROCHURE OR THE QUESTIONS AND ANSWERS CONTAINED IN IT. THIS BROCHURE DOES NOT REPLACE ANY OF THE PROVISIONS OF YOUR POLICY. YOU SHOULD READ YOUR POLICY CAREFULLY FOR COMPLETE INFORMATION AS TO THE TERMS OF YOUR COVERAGE. IF THERE IS ANY CONFLICT BETWEEN THE POLICY AND THIS SUMMARY, THE PROVISIONS OF THE POLICY SHALL PREVAIL.

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

Name and Address of Carrier