Medical Protocols Decision Point Review - Amendatory Endorsement

This endorsement changes the policy. Please read it carefully.

Your policy is amended as follows.

The Important Notice To Policyholders—Medical Protocols Decision Point Review provision under the Part II— Personal Injury Protection (PIP) Coverage provision is deleted and replaced with the following:

Important Notice To Policyholders

Please read this information and share with **your health care providers.**

This notice is to advise you that Medlogix LLC (Medlogix) is handling decision point review/pre-certification and medical service review for Lemonade, your patient's no-fault insurance carrier. Pursuant to N.J.A.C. 11:3-4, you are required to notify Medlogix of those services you intend to perform on a patient, as hereinafter explained. Lemonade has contracted with Medlogix (the "PIP Vendor") for these purposes.

The Automobile Insurance Cost Reduction Act became law in May 1998 and established certain obligations that must be satisfied so that coverage for medically necessary treatment, diagnostic testing, and durable medical equipment arising from injuries sustained in an automobile accident may be provided. Failure to abide by the following obligations may affect the authorization of medical treatment, diagnostic testing, and durable medical equipment.

Pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance has published standard courses of treatment, identified as "Care Paths", for soft tissue injuries of neck and back, collectively referred to as **identified injuries**. (See the definition in this policy.)

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**, **insured persons** or their **health care providers** must provide **us** with information about further treatment the provider intends to pursue. This is called **decision point review**. **Our** Decision Point Review Plan is available in hard copy by calling Medlogix at 1 (877) 258-CERT (2378).

The following diagnostic tests are subject to **decision point review**:

1. Brain Mapping
2. Brain Audio Evoked Potentials (BAEP)
3. Brain Evoked Potentials (BEP)
4. Computer Assisted Tomograms (CT, CAT Scan)
5. Dynatron/Cybex Station/Cybex Studies

6. Videofluoroscopy
7. H-Reflex Studies
8. Sonogram/Ultrasound
9. Needle Electromyography
10. Nerve Conduction Velocity (NCV)
11. Somatosensory Evoked Potential (SSEP)
12. Magnetic Resonance Imaging (MRI)
13. Electroencephalogram (EEG)
14. Visual Evoked Potential (VEP)
15. Thermogram/Thermography
16. Any other **diagnostic test** that is subject to the requirements of **Decision Point Review** by New Jersey law or regulation

For treatment of injuries other than an **identified injury** (soft tissue injury of the neck or back), **insured persons** or their **health care providers** are required to obtain **precertification** for all of the services listed below. If **you** or **your** providers fail to **precertify** such services, or fail to provide **clinically supported** findings that support the treatment, diagnostic tests or durable medical equipment requested, payment of bills will be subject to a penalty co-payment of 50% even if the services are determined to be medically necessary. The following treatments, services, goods and non-medical expenses require **precertification**, unless they are part of a previously approved treatment plan.

1. Non-emergency inpatient and outpatient hospital care and provider fees associated with these services
2. Non-emergency inpatient and outpatient surgical procedures, wherever performed, and provider fees associated with these services
3. All non-emergency psychological/psychiatric testing, treatment, and services
4. All outpatient psychological/psychiatric testing, treatment, and services
5. Inpatient and outpatient care for soft tissue injuries and disc injuries of the neck, back, and related structures, when furnished for any diagnoses other than those included in the Care Paths
6. Acupuncture
7. All testing and treatment for TMJ disorder or any facial pain syndrome
8. Extended care and rehabilitation facilities
9. All home health care
10. Cat Scan w/myelogram
11. PENs/PNT
12. Skilled nursing/rehabilitation services
13. Trigger point dry needling
14. Compound drugs
15. Drug screening
16. Schedule II, III and IV controlled substances, as defined by the Drug Enforcement Administration (DEA), when prescribed for more than 3 months
17. Infusion Therapy
18. Bone scans
19. Range of Motion Muscle Testing
20. Vax-D
21. Prescriptions costing more than $50

22. Non-emergency dental restoration
23. Durable medical goods, including orthotics and prosthetics, that collectively exceed $50 or rental over 30 days
24. Non-medical products, devices, services, and activities, and associated supplies, not exclusively used for medical purposes or as durable medical goods, with an aggregate cost, or monthly rental cost, in excess of $100, or used for a rental period in excess of 30 days, including but not limited to:
    a. Vehicles
    b. Modifications to vehicles
    c. Durable goods
    d. Furnishings
    e. Improvements, modifications, or alterations to real or personal property
    f. Fixtures
    g. Spa/gym memberships
    h. Recreational activities and trips
    i. Leisure activities and trips
25. Physical, occupational, speech, cognitive, or other restorative therapy or body part manipulation (including manipulation under anesthesia), including massage therapy, except as provided for **identified injuries** in accordance with **decision point review**
26. All pain management services and treatment, including but not limited to:
    a. Acupuncture
    b. Nerve blocks
    c. Manipulation under anesthesia
    d. Anesthesia when administered in conjunction with invasive techniques
    e. Epidural steroid injections
    f. Radio frequency/rhyzotomy
    g. Narcotics, when prescribed for more than three months
    h. Biofeedback
    i. Implantation of spinal stimulators or spinal pumps
    j. Trigger point injections

    except as provided for **identified injuries** in accordance with **decision point review**.

DPR—Voluntary Precertification

Insured persons and their **health care providers** are strongly encouraged to participate in a voluntary **precertification** process by providing a comprehensive treatment plan for both **identified injuries** and other injuries. An approved treatment plan means that as long as treatment is consistent with the approved plan, additional notification to **us** at **decision points** and for Treatment, Diagnostic Testing or DME requiring **precertification** is not required.

DPR—NJPIP-1099

Treatment administered in **emergency care**, and/or within ten days of the **accident**, is not subject to **decision**

point review or **precertification** requirements. This provision shall not be construed so as to require reimbursement for tests and treatment that are not medically necessary, N.J.A.C. 11:3-4.7(b).

If your provider fails to request **decision point review**/**precertification** in accordance with this plan where required, or fails to provide clinical findings that support the treatment, testing, or durable medical equipment requested, a co-payment penalty of 50% will apply. For benefits to be reimbursed in full, treatment, testing, and durable medical equipment must be medically necessary.

DPR—Complete Requests

Your health care provider must submit all requests on the Attending Provider Treatment Plan (APTP) form. A copy of the APTP form is available at http://www.nj.gov/dobi/aicrapg.htm or by contacting Medlogix at 1 (877) 258-CERT (2378).

Complete requests for **decision point review** and **precertification** must be submitted on an APTP form and must include the **insured person's** full name and birth date, the policy number, the claim number, and the date of the **accident**, and must be signed by the provider. Complete requests also must include dates of prior treatment, legible office notes, diagnoses, diagnostic tests performed including the test findings, recommended tests, pre-existing conditions, and any additional information required to review the treatment request. When an incomplete request is received, **we** will inform your provider that additional medical documentation is required. An administrative denial for failure to provide medical documentation will be issued and will remain in effect until all requested information needed to determine medical necessity regarding the requested treatment is received. Within three business days following receipt of all appropriate documentation, **we** will provide **our** determination. Pursuant to N.J.A.C. 11:3- 4.4(e) and the policy of insurance, failure to comply with **decision point review** or **precertification** requirements will result in a 50% penalty co-payment for any subject treatment or testing that is determined to be medically necessary and causally related to the **accident**. This penalty co-payment will apply to care furnished between the time notification of treatment is required and the time **we** have had an opportunity to respond after receipt of the requested additional medical documentation.

DPR—How To Submit Decision Point/Precertification Requests

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 website Medlogix's website www.medlogix.com or by contacting Medlogix at 1 (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 220, Hamilton, NJ 08619, ATTN.: Pre-Certification Department. Its phone number is 1 (877) 258-CERT (2378).

Decision point/**precertification** requests can be faxed to **us** at: 1 (856) 910-2501

All requests for pre-authorization on weekends and holidays will be handled on the next business day. Submitting requests for preauthorization before or after regular business hours and/or failure to submit the required documentation could result in a delay in receiving a final determination of **your** request.

Our review of **decision point**/**precertification** requests and/or extended treatment notifications will be completed within three business days following the day of receipt of the necessary information. Authorized testing, treatment and/or durable medical equipment (DME) is approved only for the range of dates noted in the determination letter(s).

If the injured party's treating provider fails to follow the procedures listed below, all medically necessary testing, treatment and/or DME completed after the last date in the range of dates indicated in the determination letter will be subject to a penalty co-pay of 50%, even if the services are determined to be medically necessary. In order to avoid this penalty, the injured party's treating provider must follow the appropriate procedure below:

- When medically necessary care or DME is not completed within 14 calendar days from the date in which the authorization period expires, the injured party's treating provider must request an extension, in writing, to **us** and the extension request must include the supporting reason for the extension. It can be faxed to 1 (856) 910-2501 or mailed to the following address: Medlogix LLC, 300 American Metro Blvd., Suite 220, Hamilton, NJ 08619, ATTN.: Pre-Certification Department.

- When medically necessary care or DME is completed 30 or more calendar days from the date in which the authorization period expires, the injured party's treating provider must resubmit a request to **us**. The request must be submitted in writing and must include a complete APTP form which must contain, but is not limited to, the injured party's full name, birth date, policy number, claim number, the date of the accident, diagnoses codes and all requested CPT codes listed that are intended to be used and frequency and duration of services for each code. The complete APTP form must be accompanied with appropriate and current progress notes, and results of diagnostic tests or studies relative to the requested services. It can be faxed to 1 (856) 910-2501 or mailed to the following address: Medlogix LLC, 300 American Metro Blvd., Suite 220, Hamilton, NJ 08619, ATTN.: Pre-Certification Department.

We shall respond to providers by phone as well as confirm in writing as to whether or not the medical documentation supplied by the treating provider is sufficient. If **we** fail to notify the **insured person** or provider within three business days, the **insured person** may continue with the test or treatment until a final determination is communicated to the **insured person** or the provider. In addition, if **we** are unable to make an informed determination based solely on the medical documentation, **we** may request that the **insured person** attend an Independent Medical Examination. If an Independent Medical Examination is requested, the scheduling of the appointment date for the physical examination will be completed within seven calendar days from the date that we notified the requesting party that an Independent Medical Examination would be

scheduled unless the injured person agrees with **us** to extend the time period. The physical examination itself will be scheduled to occur within 35 days from receipt of the notice.

The Independent Medical Examination will be conducted by a **health care provider** within the same specialty as the **insured person's** treating **health care provider** and will be conducted in a location reasonably convenient to the **insured person**. Results of the Independent Medical Examination and the determination regarding the precertification request will be submitted to the **insured person** in writing and to the **health care provider** in writing and by telephone within 3 business days after the examination. Please note that medically necessary treatment may proceed while the Independent Medical Examination is being scheduled and until the results are available. If the examining provider prepares a written report concerning the examination, the injured person, or his or her designee, shall be entitled to a copy of the report upon request.

In accordance with the Automobile Insurance Cost Reduction Act (AICRA) Regulations, at **our** request the **insured person** must provide all medical records and diagnostic studies/tests available before or at the time of the scheduled examination. Failure to provide the required medical records and/or diagnostic studies/tests will be considered an unexcused failure to attend the independent medical exam (IME). Failure to attend a scheduled examination without first furnishing notice at least 3 business days prior to the examination date, of the need to cancel and reschedule, will be considered an unexcused failure to attend. Rescheduled exams will be scheduled to occur within 30 days of the originally scheduled examination date. Failure to attend, with or without prior notice, any rescheduled examination will be considered an unexcused failure to attend. If the injured person has two or more unexcused failures to attend a scheduled exam, or three failures in total to attend a scheduled exam, notification will be immediately sent to the injured person or to his or her designee, and all providers treating the injured person for the diagnosis (and related diagnosis) contained in the Attending Provider 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 Provider Treatment Plan form will not be reimbursable as a consequence for failure to comply with the plan.

Unless otherwise indicated, all determinations regarding **decision point review** and **precertifications** will be provided by phone and in writing within 3 business days following the day of receipt of the request. If a determination is not rendered within 3 business days following the day of receipt of the request, the treatment or testing may proceed until the **insured person** and/or the provider have been notified that reimbursement for the treatment or testing is not authorized.

Any denial of treatment or testing based on medical necessity shall be made by a physician or dentist. Medical authorizations are not a GUARANTEE of payment. All claims are subject to regulatory eligibility and coverage investigations, benefit reductions, and/ or coverage denials as required and/or permitted by the State of New Jersey.

DPR—Voluntary Utilization Program (Waiver Of Policy Co-Payment)

As outlined in N.J.A.C. 11:3-4.8, there is a co-payment applicable to certain nonemergency care and services received from non-network providers. Currently, there is a 30% co-payment applicable to diagnostic imaging (MRI and CAT Scan), electrodiagnostic testing listed in N.J.A.C. 11:3-4.5(b)1-3 (except when performed by the treating provider in conjunction with a needle EMG), and durable medical goods greater than $50 cost or rental over 30 days. The co-payment for prescription drugs is $10.

We have a provider network that is available to **insured persons**. As outlined in N.J.A.C. 11:3- 4.8, this network is an approved network as part of a workers' compensation managed care organization pursuant to N.J.A.C. 11:6. The benefits of the network include ease of access, credentialed and quality providers, and the fact that co-payment is waived when accessing a network provider.

A secure list of preferred provider networks is available at Medlogix's website www.medlogix.com, contact Medlogix by phone at 1 (877) 258-CERT (2378), via fax at 1 (856) 910-2501, or in writing at 300 American Metro Blvd., Suite 220, Hamilton, NJ 08619.

In addition, **we** make available a Preferred Provider Organization (PPO) that includes all specialties, hospitals, outpatient and urgent care facilities. The use of a provider from this PPO is strictly voluntary and is provided as a service to **insured persons**. A co-payment penalty will not be applied if you choose to select a provider outside this preferred provider network. **Our** preferred providers have facilities located throughout the state. Information regarding the PPO network is available to you at Medlogix's website at www.medlogix.com, contact Medlogix by phone at 1 (877) 258-CERT (2378).

DPR—Penalty

As outlined in N.J.A.C. 11:3-4.4(e), failure to request **decision point review** or **precertification** as required in this **Decision Point Review**/**Precertification** plan will result in a 50% co-payment penalty. This co-payment penalty will be in addition to any co-payment set forth elsewhere in Part II of the policy. Co-payments and deductibles will first be applied to the eligible charges and then co-payment penalties will be applied for failure to precertify.

DPR—Application Of Co-Payments And Deductibles

In accordance with N.J.A.C. 11:3-4.4(h), co-payments and deductibles will be applied in the following order:

1. If applicable, co-payment penalty described in N.J.A.C. 11:3-4.4 (e) and (g);
2. Insured deductible as described in N.J.A.C. 11:3-4.4 (a) and (b);
3. Insured co-payment as described in N.J.A.C. 11:3-4.4 (a).

Assignment Of Benefits

Benefits under this policy part are not assignable except to a **health care provider** for **medical expenses** representing covered services and/or supplies furnished by the **health care provider** to an **insured person**.

In order for any assignment of benefits to be valid, the **health care provider** must agree, in writing as part of the assignment, to comply fully with **our** Decision Point Review Plan, all **precertification** requirements, and all the terms and conditions of the policy. An assignment that does not explicitly contain such an agreement is invalid.

The **health care provider** must also agree, in writing as part of the assignment, to hold harmless the **insured person**, **us**, and **our** vendor for any reduction in benefits caused by the **health care provider's** failure to fully comply with the terms of **our** Decision Point Review Plan, all **precertification** requirements, or the terms and conditions of the policy.

Any and all assignments of benefits by an **insured person** to a **health care provider** shall become void and unenforceable under the following conditions:

1. coverage is not afforded under the policy;
2. a **health care provider** of services and/or supplies does not submit to an Examination Under Oath when **we** request same;
3. a **health care provider** of services and/or supplies does not comply with all requests for medical records or test results;
4. a **health care provider** does not comply with all the requirements, duties and conditions of the policy, including but not limited to all duties of cooperation listed in the "YOUR DUTIES" part of the policy; or
5. a **health care provider** does not comply with the "Dispute Resolution" provisions in Part II of the policy and in **our** approved Decision Point Review Plan, including utilization of the Internal Appeal Process.

Internal Appeal Process And Dispute Resolution For Insured Persons

If the **insured person** disagrees with our determination related to **decision point review**, **precertification**, or payment of **medical expenses**, including bill review and payment, the **insured person**, or the **health care provider**, may submit a written internal appeal for reconsideration of the decision. This written request must be submitted within 15 days of the date of the determination that is being challenged. All such requests should include the basis for the appeal. The **insured person**, and one or more **health care providers**, may be requested to submit additional documentation in order to complete the internal review.

Requests for reconsideration/internal appeals should be submitted in writing to **us** at:

PO Box 66730 Phoenix AZ 85082 or
Fax 480-566-9659
Email claimsdocuments@metromile.com

All such requests will be reviewed within 10 business days from receipt of the notice and all supporting documents. A Medical Director will be available to consult with the **health care provider** during the reconsideration process. A final decision will be communicated to the **insured person**, and the **health care provider**, in writing within 10 business days of receipt of the request and/or receipt of any supporting documentation **we** may request.

If the **insured person** or **health care provider** retains counsel to represent them during this process, they do so strictly at their own expense. No counsel fees or costs incurred during this process shall be compensable.

Pursuant to N.J.A.C. 11:3-5.1, and the policy, any dispute submitted by an **insured person** that has not been resolved through this process may be submitted to Alternate Dispute Resolution.

However, any **health care provider** who is a valid assignee must follow the process set forth in the "Internal appeal process and dispute resolution for **health care providers** with a valid assignment of benefits" section in the policy, and comply with all provisions therein, as the only recognized means of resolving disputes for **health care providers** holding valid assignments. Those provisions are also set forth here.

Internal Appeal Process And Dispute Resolution For Health Care Providers With A Valid Assignment Of Benefits

The internal appeals process shall permit a **health care provider** who has been assigned benefits pursuant to N.J.A.C. 11:3-4.9, or has a power of attorney from the injured party, to participate in the internal appeals process for reconsideration of an adverse decision.

All internal appeals shall be filed using the form established by the Department by Order in accordance with N.J.A.C. 11:3-4.7(d). A properly submitted appeal form must be completed in its entirety, including, but not limited to the minimum required fields as indicated by an asterisk (*). Further, an appeal rationale narrative is required to be included within these forms. Failure to comply with these requirements will result in an administrative denial of the appeal. The appeal form and all supporting documentation must be submitted by the **health care provider** to Medlogix at the address or fax number designated for appeals as follows:

Medlogix
Fax: (856) 910-2501 or
Address: 300 American Metro Blvd., Suite 220,
Hamilton, NJ 08619

There are two types of internal appeals:

1. Pre-service: Appeals of **decision point review** and/or **precertification** denials or modifications prior to the performance or issuance of the requested medical procedure, treatment, diagnostic test, other service and/or durable medical equipment (collectively known as "services")
2. Post-service: Appeals subsequent to the performance or issuance of the services

Pursuant to N.J.A.C. 11:3-4.7B(b), each issue shall only be required to receive one internal appeal review, by the insurer prior to making a request for alternate dispute resolution.

Pre-service Appeals

A pre-service appeal shall be submitted in writing to Medlogix no later than (30) thirty days after receipt of a written denial or modification of requested services.

A final decision will be communicated in writing to the **health care provider** who submitted the appeal within (14) fourteen days from the date Medlogix received the properly submitted appeal.

All pre-service appeals received after (30) thirty days from the date of receipt of the adverse decision notice shall be acknowledged as "Late Appeals." All pre-service appeals that are acknowledged as "Late Appeals" will not be processed. The pre-service appeal form must be completed in its entirety, including, but not limited to the minimum required fields as indicated by an asterisk (*).Further, an appeal rationale narrative is required to be included within these forms. Failure to comply with this requirement will result in an administrative denial of the appeal.

If a pre-service appeal is not properly submitted within (30) thirty days from the date the provider has received notice of the adverse decision, the **health care provider** may submit another **decision point review** request for the services in accordance with the aforementioned section in this DPR Plan named "How to Submit Decision Point and/or Precertification Requests".

Post-Service Appeals

A post-service appeal shall be submitted in writing to Medlogix 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. The post-service appeal form must be completed in its entirety, including, but not limited to the minimum required fields as indicated by an asterisk (*).Further, an appeal rationale narrative is required to be included within these forms. Failure to comply with this requirement will result in an administrative denial of the appeal.

A final decision will be communicated in writing to the **health care provider** who submitted the appeal within (30) thirty days from the date Medlogix received the properly submitted appeal.

Pursuant to N.J.A.C. 11:3-5.1, any appeal properly submitted that has not been resolved through the internal appeal process may be submitted to Alternate Dispute Resolution.

If the **insured person** or **healthcare provider** retains counsel to represent them during the appeal process, they do so strictly at their own expense. No counsel fees or costs incurred during the appeal process shall be compensable.

Health Care Providers Not Holding A Valid Assignment Of Benefits

A **health care provider** not holding a valid assignment of benefits shall have no right to present any claim or bring any action directly against **us** for benefits under the policy, regardless of forum. Accordingly, such **health care provider** may not request or engage in Alternate Dispute Resolution as provided for in N.J.S.A.

39:6A-5.1. This paragraph does not preclude a **health care provider** that is not holding a valid assignment of benefits from participating in the request for internal appeal/reconsideration process set forth in the preceding section.

All other terms and conditions of the policy remain unchanged.

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