

# ESURANCE INSURANCE COMPANY OF NEW JERSEY

Decision Point Review/PreCertification Plan for:  
Esurance Insurance Company of New Jersey (NAIC# 21741)  
(Referred to as EICNJ)

## Introduction

The primary objective of EICNJ's Decision Point Review/PreCertification Plan is to provide for the timely payment of medically necessary treatment and testing whenever an eligible insured is injured in a covered automobile accident. We encourage open communication with Insureds and medical providers to ensure that the medical review process does not delay the planned course of treatment designed to return a patient to his/her preaccident status.

Another important objective of our DPR plan, which protects all of our Insureds, is to mitigate payments for treatment and testing which is not medically necessary.

"Medically necessary" as defined in our policy means that the medical treatment or diagnostic test is consistent with the clinically supported symptoms, diagnosis or indications of the injured person, and:

1. The treatment is the most appropriate level of service that is in accordance with the standards of good practice and standard professional treatment protocols including the Care Paths and other protocols recognized or designated by the Commissioner of Banking and Insurance of New Jersey, as applicable;
2. The treatment of the injury is not primarily for the convenience of the injured person or provider; and
3. Does not include unnecessary testing or treatment.

## Effective Date

The effective date of the plan is the date approved by the Department of Banking and Insurance.

## Plan Outline

The following Plan Outline provides a detailed description of the EICNJ Decision Point Review/Pre-Certification Plan. The outline is designed to correspond with the numbering used in 11:34.7(c) with the number of each section of the Outline corresponding to each section of the regulation for easy reference. Supporting documents are included in the Plan Binder and are referenced accordingly in each section of the Outline.

### **1. Identification of Vendor**

EICNJ's Decision Point Review / PreCertification Plan Administrator is:

Horizon Casualty Services, Inc.  
33 Washington Street, 11th Floor  
Newark, NJ 071023194  
www.horizonbcbsnj.com  
(866) 8661427 – phone  
(973) 6227265 – fax

## ESURANCE INSURANCE COMPANY OF NEW JERSEY

Details concerning Horizon's Medical Director Program, Precertification/Decision Point Review procedures, and workflows are all provided in the Horizon vendor filing, which has been submitted under separate cover.

### **2. Identification of Specific Medical Procedures, Treatments, Diagnoses, Diagnostic Tests, Durable Medical Equipment, and Other Services Subject to Decision Point Review / Pre-Certification**

The following is a comprehensive list of all services and supplies requiring precertification under the EICNJ Plan. This list is unchanged from our previously approved DPR plan.

1. Nonemergency inpatient and outpatient hospital care.
2. All nonemergency surgical procedures.
3. Durable medical equipment (including orthotics and prosthetics) costing greater than \$50, or rental greater than 30 days
4. Extended care rehabilitation facilities
5. Home health services.
6. Infusion therapy
7. Outpatient psychological/psychiatric services and testing.
8. All physical, occupational, speech, cognitive or other restorative therapy, or body part manipulation including Manipulation Under Anesthesia, except that provided for Identified Injuries in accordance with Decision Point Review
9. All pain management services, except that provided for Identified Injuries in accordance with Decision Point Review
10. All nonemergency diagnostic testing services, except those provided for Identified Injuries in accordance with Decision Point Review
11. Nonemergency dental restoration

### **3. Informational Materials for Policyholders, Eligible Injured Persons (EIP), and Providers**

EICNJ believes that adequate and appropriate communication with our Policyholders, EIPs, and Providers is not only good customer service, but it is essential for the smooth and effective functioning of the Decision Point Review/PreCertification and claims investigation process. The more we can do to eliminate ambiguity for claimants and providers by carefully explaining the process to them, the less we will experience disputes and unsatisfied customers.

To that end, EICNJ utilizes several avenues to distribute important information concerning the Decision Point Review / PreCertification process to Policyholders, EIPs, and Providers. The requirement column in the following table is numbered to correspond with the requirements outlined in 11:34.7(d) 19 of the revised regulations for easy reference.

Copies of all relevant informational materials are attached in Section II for review.

ESURANCE INSURANCE COMPANY OF NEW JERSEY

EICNJ Notice Materials	Requirements of 11:34.7(d) Covered by Materials	Recipient of Notice	Method/Time of Delivery
S13392 “Claim Satisfaction” Policy Addendum & Policy ID Card	1, 5, 6, 7, 8, 9	Policyholders	Attached to policy at inception and renewal.
Claim Acknowledgement Letter and “Personal Injury Protection and Decision Point Review/PreCertification” brochure	1, 5, 6, 7, 8, 9	All Claimants	Letter sent by EICNJ Claim Representative to each Claimant or their designated representative upon receipt of the claim.
Point of Contact Letter	1, 2, 3, 4, 6, 7, 8, 9	Providers, Claimants	Letter sent by Horizon to each provider upon receipt of notice of treatment. Copy also sent to claimant.

**4. Procedures for Prompt Review of PreCertification and Decision Point Review Requests**

The procedures for review of PreCert and DPR requests under the EICNJ DPR Plan are outlined in the Horizon Casualty Services filing, which has been submitted under separate cover.

**5. Procedures for Scheduling Independent Medical Examinations (IMEs)**

The procedures for scheduling IMEs are outlined in the Horizon Casualty Services filing, which has been submitted under separate cover.

The purpose of an IME scheduled pursuant to this Plan is to provide a timely review of proposed medical care in order to determine the medical necessity of further treatment or testing and/or to verify the causal relationship of the claimed injuries to the accident. If a physical/mental examination of the Eligible Injured Person (EIP) is requested pursuant to this Plan, we or our Plan Administrator will notify the EIP of the date, time and location of the examination. The appointment for the IME will be scheduled within seven business days of the Plan Administrator’s receipt of the request for DPR/PreCertification unless the injured person agrees to extend the time period. The IME will be conducted by a practitioner in the same discipline as the treating provider at a location that is reasonably convenient to the EIP.

If requested by us or the Plan Administrator, the EIP may be required to provide medical records, test results, diagnostic films, and other pertinent information to the IME physician in order to facilitate a proper review of the EIP’s case. This information must be provided no later than at the time of the examination. The EIP is also required to present proper photo identification to the IME physician at the time of the examination.

When an IME is scheduled, a notice will be sent to all known treating providers advising them of the examination and the consequences of the EIP’s unexcused failure to attend more than one scheduled appointment.

Treatment may proceed while the IME is being scheduled and until the results are available. A copy of the written IME report, if prepared, will be provided to the EIP or his/her representative upon request.

**Consequences of Failure to Attend Scheduled IMEs.**

The EIP is expected to attend each examination as scheduled by us or our Plan Administrator.

Failure of an EIP to attend a scheduled examination without a minimum of 3 business days notice to the examining physician or the Plan Administrator shall constitute an **unexcused** failure to attend.

Failure of an EIP to attend a scheduled examination will be considered excused if the EIP notifies the examining physician or Plan Administrator at least 3 business days prior to the examination date and reschedules the appointment for a date, not to exceed 35 calendar days from the date of the original appointment.

If an EIP has an otherwise **excused** failure to attend a scheduled examination and does not reschedule the appointment to occur within 35 calendar days of the original appointment date, the failure to attend shall be deemed **unexcused**.

If an EIP reschedules an examination for a date more than 35 calendar days from the date of the original appointment, any failure to attend the rescheduled appointment will be **unexcused**.

If an EIP attends a scheduled examination, but fails to supply all requested medical records, test results, diagnostic imaging films and other pertinent materials; and proper photo identification it shall be deemed an unexcused failure to attend the examination and the examination will not take place.

If an EIP has more than one unexcused failure to attend a scheduled examination, notification will be sent to the EIP or his/her representative and all known treating providers advising that payment for all treatment, diagnostic testing, prescription drugs, and durable medical equipment provided on or after the date of notification and relating to the diagnosis code(s) and/or corresponding family of codes associated with the DPR/PreCertification request that necessitated scheduling of the examination will be denied.

In such cases, no future treatment, diagnostic testing, prescription drugs, or durable medical equipment associated with the relevant diagnosis code(s) will be reimbursable under our policy.

**6. Reconsideration Procedure – 1st Level Appeal.**

The procedure for internal appeal of a decision by the vendor to modify or deny reimbursement for treatment or testing is outlined in the Horizon Casualty Services filing, which has been submitted under separate cover.

A complete description of our entire Internal Appeals process is provided under Section 7.

**7. Restrictions on Assignment of Benefits and Dispute Resolution**

EICNJ has included restrictions on the Assignment of Benefits under our policy. A copy of the revised endorsement is included in Section IV of the plan binder for easy reference.

The revised policy allows any EIP to assign his or her benefits to any “health care provider” that is providing the EIP with covered services or supplies in conjunction with their Personal Injury Protection claim. In order for any assignment to be valid, the “health care provider” must agree, in writing as part of the assignment, to fully comply with our Decision Point Review/PreCertification plan and all of the terms and conditions of our policy including precertification, decision point reviews, deductibles, copayments, exclusions, duties of cooperation, and conditions for dispute resolution.

The provider must also agree, in writing as part of their assignment, to hold harmless the Insured, the Company, and the Company’s Vendor(s) for any reduction in benefits caused by the provider’s failure to comply with the terms of the Decision Point Review / PreCertification plan or our Policy.

An assignment that does not specifically agree to these conditions will not be considered valid. In addition, any and all assignments become void and unenforceable under certain conditions including:

- Coverage is not afforded under the policy.
- An “Insured” or “Provider” does not submit to Examination Under Oath.
- A “provider” does not comply with the Dispute Resolution provisions of the policy including utilization of the Internal Appeals Process.
- A “provider” does not comply with requests for medical records, test results, or other relevant medical documentation.
- An “insured” or “provider” does not comply with all requirements, duties, and conditions of the policy and the Decision Point Review / PreCertification plan.

While we make every effort to provide fair and timely payment of benefits on all valid claims, there are situations where a dispute will arise between us and an assignee over payment of PIP benefits. Often, such disputes are simple matters that, when brought to our attention, can be resolved quickly and amicably without the need for costly and time consuming litigation.

In an effort to avoid such unnecessary litigation, which is ultimately very costly to our policyholders, we have included a requirement in our policy that any assignee who has a dispute must utilize our Internal Appeals process prior to filing any form of litigation.

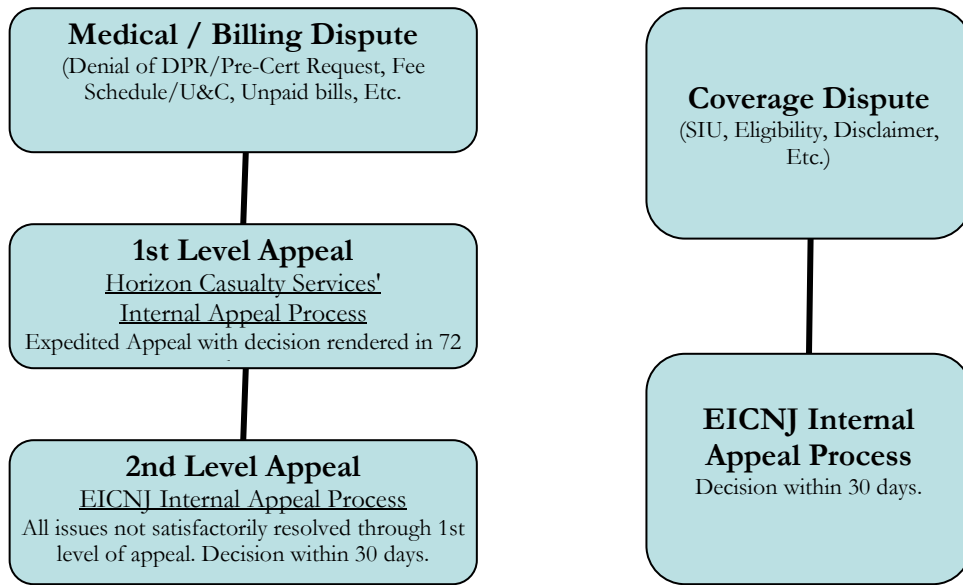
When a dispute arises, it will either involve Medical/Billing issues or Coverage Issues. For Medical/Billing issues such as denial of a Decision Point Review or PreCertification request; a fee schedule or Usual & Customary dispute; or alleged failure to make timely payment of medical bills, there are two levels of appeal.

At the first level of appeal, the matter is submitted to Horizon Casualty Services via their internal appeals process, which is outlined in their plan filing. This process results in a decision being rendered within 72 hours of Horizon’s receipt of the request and all supporting documentation. If the matter is not satisfactorily resolved through the Horizon Appeal process, it is then escalated to the second level of appeal.

At the second level, the appeal is submitted to EICNJ for review under the Internal Appeals Process outlined in our policy. In addition to second level Medical and Billing issues, all coverage issues are submitted directly to EICNJ since they are outside of Horizon’s purview as the Plan Administrator. EICNJ will investigate the matter under appeal and render a decision within 30 days of our receipt of the appeal.

ESURANCE INSURANCE COMPANY OF NEW JERSEY

The Appeals Process is illustrated as follows:



To utilize the EICNJ Appeal Process for second level appeals or coverage appeals, the assignee simply needs to send notification of their dispute, in writing, including any supporting documents such as copies of unpaid bills or medical records to us at:

**Esurance Insurance Company of New Jersey  
P.O. Box 623  
Basking Ridge, NJ 07920**

**Attn: PIP Appeals Coordinator**

To ensure proper receipt of the dispute by us, it should be submitted via certified mail/return receipt requested through the US Postal Service or via another courier that provides proof of delivery such as Federal Express. Proof of receipt by us must be provided at our request pursuant to our policy.

Should the assignee choose to retain an attorney to handle the Appeal Process, they do so strictly at their own expense pursuant to our policy.

If we are unable to resolve the matter within 30 days after having received proper notice, the assignee is free to litigate the matter through the approved Dispute Resolution Organization or the courts.

## 8. Network Information

EICNJ offers Voluntary Utilization Networks for Diagnostic Imaging and Electrodiagnostic testing, Durable Medical Equipment, and Prescription Drugs. Each of these Networks is offered through a different vendor as outlined below.

- A. Prescription Drugs – Horizon Casualty Services through their Advanced PCS Network.
- B. Diagnostic Imaging/Electrodiagnostic Testing – Atlantic Imaging Group
- C. Durable Medical Equipment – Procura Managed Care Network.

Benefits may be obtained through each of these networks via a single point of contact – Horizon Casualty Services. Horizon provides an explanation of the Voluntary Utilization process to each treating doctor in their “Provider Letter” and they include a list of Diagnostic & DME Network providers as an attachment to each letter. (A copy of Horizon’s Provider Letter specific to EICNJ’s account is included in Section II of the binder for reference.) In addition, they provide a toll free number and a web address for access to the Advanced PCS pharmacy network for prescription drugs. Information on all Voluntary Utilization Networks is also available to any party to the claim through Horizon’s toll free number.

Each of the listed networks meets the requirements outlined in 11:34.8 (a) as follows:

- Horizon Casualty Services is an approved Workers Compensation Managed Care Organization.
- Atlantic Imaging Group is approved under the FOCUS Healthcare Management, Inc., Genex Services, Inc., and Procura Management, Inc. plans.
- Procura Management, Inc is an approved Workers Compensation Managed Care Organization.

Copies of the vendor contracts are located in Section III. Copies of Atlantic Imaging Group’s Workers Comp MCO contracts are located in Section V along with a list of approved Workers Comp MCOs for reference.

## Notice Requirements

The terms and conditions of both our existing PIP Endorsement and our revised PIP Endorsement require any “insured” to promptly notify us of any claim and provide us with information including:

- How, when and where the accident happened.
- A detailed description of the injuries sustained in the accident.
- A detailed description of all preexisting injuries and/or conditions the “insured” may have.
- The names of any physicians and/or medical facilities consulted by the “insured” with respect to the injuries along with their contact information.

Pursuant to 11:34.4(e) 13, EICNJ requires any “insured” to adhere to the reporting requirements outlined above. Failure to supply the required information shall result in a reduction in the amount of reimbursement of the eligible charge for medically necessary expenses that are incurred by the “insured” after he/she should have notified us of the loss according to the following schedule:

- Notice received 30-59 days after the date of the accident – 25%
- Notice received 60 or more days after the date of the accident – 50%

These penalties apply in addition to any other deductibles, copayments, and penalties that may otherwise apply to the claim.

This provision does not relieve any treating medical provider from their obligation to promptly provide notification of treatment under NJAC 11:325 also known as the ‘21 Day Rule’.



Horizon Casualty Services, Inc.

Horizon Casualty Services, Inc.

33 Washington Street  
11th Floor  
Newark, NJ 07102-3194  
(866) 866-1427 – phone  
(973) 622-7265 – fax  
www.horizon-bcbsnj.com

February 9, 2005

Re: Patient:  
SSN:  
Date of Loss:  
Claim Number:

Dear Provider:

We have been informed that the above named patient will be receiving treatment at your facility for injuries sustained in a motor vehicle accident. Horizon Casualty Services has been contracted by Esurance Insurance Company of New Jersey (EICNJ) to administer the Decision Point Review, Pre-Certification, and Voluntary Network processes on their behalf. Please read this entire letter carefully since it provides important information concerning how claims under EICNJ's Personal Injury Protection coverage will be handled.

Pursuant to N.J.A.C. 11:34, you are required to notify us prior to performing certain diagnostic testing or treatment on this patient. The specific notification requirements are outlined in detail below and they apply to any such testing or treatment rendered on or after the tenth day following the motor vehicle accident. These requirements do not apply to emergency care.

### **Decision Point Review**

Under N.J.A.C. 11:34, the New Jersey Department of Banking and Insurance has published standard courses of treatment, known as Care Paths, for soft tissue injuries of the neck and back, collectively referred to as Identified Injuries (see Exhibit A) along with guidelines for the use of certain diagnostic tests.

The Care Paths provide that treatment be evaluated at certain intervals called Decision Points, which are represented by hexagonal boxes on the Care Paths. At these Decision Points, you must provide us with information about further treatment that you intend to provide so that we may perform a Decision Point Review. In addition, the administration of any test on the list provided in Exhibit B also requires a Decision Point Review regardless of the diagnosis.

Detailed information regarding the Care Paths and accompanying rules, are available on the internet on the New Jersey Department of Banking and Insurance website at [www.nj.gov/dobi/aicrapg.htm](http://www.nj.gov/dobi/aicrapg.htm) or by calling Horizon Casualty Services, Inc. at (866) 866-1427.

Please be advised that failure to submit requests for decision point review, or failure to provide clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested will result in a 50% copayment, even if the services are determined to be medically necessary and causally related to the motor vehicle accident. The copayment applies between the time notification to the insurer was required and the time that proper notification is made and the insurer has an opportunity to respond.



Horizon Casualty Services, Inc.

Horizon Casualty Services, Inc.

33 Washington Street  
11th Floor  
Newark, NJ 07102-3194  
(866) 866-1427 – phone  
(973) 622-7265 – fax  
www.horizon-bcbnsj.com

**Mandatory Pre-Certification:**

As described in N.J.A.C. 11:34.8, insurers may require precertification of certain treatments or diagnostic tests for diagnoses or treatments not included in the Care Paths. If your patient does not have an Identified Injury, you are required to obtain precertification of all services itemized in Exhibit C.

If you fail to submit requests for precertification, or fail to provide clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested, a 50% copayment will apply, even if the services are determined to be medically necessary and causally related to the motor vehicle accident. The copayment applies between the time notification to the insurer was required and the time that proper notification is made and the insurer has an opportunity to respond.

You are encouraged to maintain communication with Horizon Casualty Services, on a regular basis since pre-certification requirements may change.

**Voluntary Precertification:**

You are encouraged to participate in a voluntary precertification process by providing Horizon Casualty Services with a comprehensive treatment plan for both identified and other injuries. Horizon Casualty Services will utilize nationally accepted criteria and the Care Paths to work with you to certify a mutually agreeable course of treatment to include itemized services and a defined treatment period.

In consideration for your participation in the voluntary precertification process, the bills you submit, when consistent with the precertified services, will be paid without further review for medical necessity. In addition, having an approved treatment plan means that as long as treatment is consistent with the plan, additional notification to Horizon Casualty Services at decision points or for services included in the approved treatment plan that would otherwise be subject to precertification is not required. Additional services outside of the approved treatment plan that are subject to precertification must still be precertified. If you continue to participate in the voluntary precertification process for subsequent services, payment for precertified services will be made without further review for medical necessity.

**How to submit Decision Point Review and Precertification Requests:**

In order for us to properly evaluate the requested treatment or testing, we require that you provide us with all of the following information:

- Complete past medical history.
- Dates and description of previously rendered treatment.
- Diagnosis including ICD9 codes and clinical symptoms.
- List of all diagnostic tests performed and their
- List of all preexisting conditions.
- Prognosis.
- Description of recommended tests.
- Description of recommended treatment. results.

To facilitate your submission, we have enclosed a *Uniform Attending Provider Treatment Plan Form* as established by Department Order A04143 that you may use. Please return this completed form, along with the information outlined above, to Horizon Casualty Services via Fax to 973-622-7265. Additional copies of this form are available on the NJ Department of Banking and Insurance website at <http://www.nj.gov/dobi/aicrapg.htm> or on the Esurance website at [www.esurance.com](http://www.esurance.com).



Horizon Casualty Services, Inc.

Horizon Casualty Services, Inc.

33 Washington Street  
11th Floor  
Newark, NJ 07102-3194  
(866) 866-1427 – phone  
(973) 622-7265 – fax  
[www.horizon-bcbsnj.com](http://www.horizon-bcbsnj.com)

### **Completing the Review Process:**

Our review of your submission will be completed within 3 business days of receipt of the necessary information from you. Notice of our determination will be made to your office by telephone and confirmed in writing. If we fail to notify you within 3 business days, you may proceed with the testing or treatment until a final determination is communicated to you. In addition, if an independent physical or mental examination is required, treatment may proceed while the exam is being scheduled and until the results become available. Please keep in mind that any treatment rendered during this time is still subject to review for medical necessity.

Our review of your submission may result in one of the following outcomes:

- Requested service is certified.
- In the event we receive insufficient information to render an informed determination regarding the requested service, an administrative noncertification will be issued until we receive documentation sufficient to properly evaluate the request. If the documentation requested is not received within 15 days of the date of the administrative noncertification, the initial request will be forwarded to a Horizon Casualty Services medical director to review.
- In the event that we must amend the requested services (frequency, duration, intensity or place of service/treatment); your office will be notified by telephone with confirmation in writing. In addition, a Horizon Casualty Services medical director will be available to discuss the case with you should you desire.
- In the event that we are unable to render an informed determination based solely on the medical records, we may require the patient to attend an Independent Medical Examination (IME) to determine the necessity of continued treatment. If an IME is required, we may request that you provide additional medical records to the provider who will be conducting the examination. In accordance with N.J.A.C. 11:34.7(e), the requested records must be provided no later than the time of the examination. Please refer to Exhibit D for the IME requirements under N.J.A.C. 11:34.7(e). The results of the IME will be communicated to you within 3 business days of the examination. A copy of the examining physician's written report, if prepared, will be made available upon request.
- In the event we that are unable to certify a request from your office, you will be notified by telephone with confirmation in writing. Denials of treatment for decision point review or pre-certification requests on the basis of medical necessity must be determined by a physician, and in the case of treatment by a dentist, the denial must be by a dentist, in accordance with N.J.A.C. 11:3-4.7(c) 4. A Horizon Casualty Services medical director will be available to discuss the case with you. If the request is for a surgical procedure, we will assist the patient with scheduling a second surgical opinion, at the expense of Esurance Insurance Company of New Jersey.

Please be aware that, pursuant to N.J.A.C. 11:34.4(d) and the EICNJ policy, failure to submit requests for Decision Point Review or precertification or failure to submit clinically supported findings to support the treatment, diagnostic test or durable medical equipment will result in a 50% copayment for any subject treatment or testing that is determined to be medically necessary and causally related to the motor vehicle accident. The copayment applies between the time notification to the insurer was required and the time that proper notification is made and the insurer has an opportunity to respond.



Horizon Casualty Services, Inc.

Horizon Casualty Services, Inc.

33 Washington Street  
11th Floor  
Newark, NJ 07102-3194  
(866) 866-1427 – phone  
(973) 622-7265 – fax  
[www.horizon-bcbsnj.com](http://www.horizon-bcbsnj.com)

### **Reconsideration Process – 1st Level Appeal:**

If we deny a request for Decision Point Review or PreCertification of any medical services or procedures under the EICNJ policy, the clinical rationale for this determination will be made available at your request. You may contact us at (866) 8661427 to request the clinical rationale.

Should you disagree with our determination concerning your request, you are entitled to seek a reconsideration of the decision from us within 30 days of the date of the denial letter. All requests for reconsideration should be submitted, in writing, to Horizon Casualty Services, 33 Washington Street, 11th Floor, Newark, NJ 071023194, Attention: PIP Services Dept., or you may fax your request to (973) 6227265. All requests for reconsideration will be reviewed within three business days by A Horizon Casualty Services Medical Director, who will be available to consult with you during the reconsideration process. A final decision will be communicated to you in writing within 3 business days of Horizon’s receipt your request for reconsideration and/or their receipt of any documentation they request from you in order to properly assess your application for reconsideration. Any dispute not resolved through the first level of appeal must be referred to the second level of appeal through EICNJ as outlined in their Decision Point Review Plan.

### **Voluntary Network Services:**

Please note that the EICNJ policy includes a Voluntary Network Program for diagnostic testing, durable medical equipment (over \$50.00) and prescription drugs. If an Eligible Injured Person utilizes a conveniently located network provider for these services, the 30% out of network copayment in the EICNJ policy (\$10 for prescription drugs) will be waived. The voluntary network services may only be offered for and the copayment may only apply to those tests specified in N.J.A.C. 11:34.8(b), which are listed in Exhibit E.

To locate a Voluntary Network provider in your area, simply contact HCS at 866-866-1427. Should you require any prescription drugs or durable medical equipment, please go to [www.horizonbcbsnj.com](http://www.horizonbcbsnj.com) or contact HCS at (866) 8661427 for a participating network pharmacy or durable medical equipment supplier in your area. If you need additional information or assistance regarding the Voluntary Utilization program or the network providers, please contact Horizon Casualty Services at (866) 866-1427.

### **Assignment of Benefits and Dispute Resolution:**

Any Eligible Injured Person (EIP) may assign their benefits to a “Health Care Provider” that is providing covered services or supplies in conjunction with the EIP’s accident related injuries. However, in order for any assignment of benefits to be valid, the provider must agree, in writing, to comply fully with the EICNJ Decision Point Review/Pre-Certification plan and all the terms and conditions of the EICNJ policy including, but not limited to, pre-certification/decision point reviews, exclusions, deductibles, copayments, duties of cooperation, and dispute resolution requirements.

If you elect to accept an assignment from an EIP, you will be required to hold harmless the EIP, EICNJ, and Horizon Casualty Services for any reduction of benefits caused by your failure to comply with the terms of the policy and/or the Decision Point Review / Precertification plan. You also agree that any disputed issues involving treatment or services provided to the EIP must be resolved through the dispute resolution process established by the EICNJ policy and Decision Point Review / Pre-Certification plan. **The EICNJ dispute resolution process requires that all assignees utilize the EICNJ Internal Appeal process prior to filing any form of litigation with respect to PIP disputes.**

For details concerning the EICNJ Internal Appeal process and its requirements, or if you would like to review the policy and your patient cannot provide you with a copy, please contact your EICNJ Claim Representative for



Horizon Casualty Services, Inc.

Horizon Casualty Services, Inc.

33 Washington Street  
11th Floor  
Newark, NJ 07102-3194  
(866) 866-1427 – phone  
(973) 622-7265 – fax  
[www.horizon-bcbsnj.com](http://www.horizon-bcbsnj.com)

assistance. In addition, the Internal Appeals process is outlined in detail in the EICNJ Decision Point Review / Pre-Certification Plan, which is available online at [www.esurance.com](http://www.esurance.com) for your reference.

**Precertification of services by Horizon Casualty Services does not guarantee payment, which is subject to the patient's eligibility for benefits as well as the terms, conditions and exclusions of the EICNJ policy. Coverage for a given claim is determined solely by EICNJ.**

The staff at Horizon Casualty Services is available to you and your patient, to answer questions and assist with the Decision Point Review / Pre-Certification process. Thank you for your cooperation.

Sincerely,

Horizon Casualty Services, Inc.  
PIP Services Department

enclosures: Exhibit A – Identified Injuries  
Exhibit B – Diagnostic tests subject to Decision Point Review  
Exhibit C Services that require Precertification  
Uniform Attending Provider Treatment Plan Form  
Exhibit D – IME requirements under N.J.A.C. 11: 34.7(e)  
Exhibit E – List of applicable diagnostic tests  
List of Voluntary Network Providers

cc: Claimant

## Exhibit A – Identified Injuries

### Cervical Spine: Soft Tissue Injury:

- 728.0 Disorders of muscle, ligament and fascia
- 728.85 Spasm of muscle
- 739.0 Non allopathic lesions – not elsewhere classified
- 739.1 Somatic dysfunction of cervical region
- 847.0 Sprains and strains of neck
- 847.9 Sprains and strains of back, unspecified site
- 922.3 Contusion of back
- 922.31 Contusion of back, excludes interscapular region
- 953.0 Injury to cervical root

### Cervical Spine: Herniated Disc/Radiculopathy:

- 722.0 Displacement of cervical intervertebral disc without myelopathy
- 722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
- 722.70 Intervertebral disc disorder with myelopathy, unspecified region
- 722.71 Intervertebral disc disorder with myelopathy, unspecified region
- 728.0 Disorders of muscle, ligament and fascia
- 739.0 Non allopathic lesions – not elsewhere classified
- 953.0 Injury to cervical root

### Thoracic Spine: Soft Tissue Injury:

- 728.0 Disorders of muscle, ligament and fascia
- 728.85 Spasm of muscle
- 739.0 Non allopathic lesions – not elsewhere classified
- 739.2 Somatic dysfunction of thoracic region
- 739.8 Somatic dysfunction of rib cage
- 847.1 Sprains and strains, thoracic
- 847.9 Sprains and strains of back, unspecified site
- 922.3 Contusion of back
- 922.33 Contusion of back, interscapular region

### Thoracic Spine: Herniated Disc/Radiculopathy:

- 722.0 Displacement of cervical intervertebral disc without myelopathy
- 722.1 Displacement of thoracic or lumbar intervertebral disc without myelopathy
- 722.11 Displacement of thoracic intervertebral disc without myelopathy
- 722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
- 722.70 Intervertebral disc disorder with myelopathy, unspecified region
- 722.72 Intervertebral disc disorder with myelopathy, thoracic region
- 728.0 Disorders of muscle, ligament and fascia
- 739.0 Non allopathic lesions – not elsewhere classified

Lumbar-Sacral Spine: Soft Tissue Injury:

- 728.0 Disorders of muscle, ligament and fascia
- 728.85 Spasm of muscle
- 739.0 Non allopathic lesions – not elsewhere classified
- 739.3 Somatic dysfunction of lumbar region
- 739.4 Somatic dysfunction of sacral region
- 846 Sprains and strains of sacroiliac region
- 846.0 Sprains and strains of lumbosacral (joint) (ligament)
- 846.1 Sprains and strains of sacroiliac ligament
- 846.2 Sprains and strains of sacrospinatus (ligament)
- 846.3 Sprains and strains of sacrotuberous (ligament)
- 846.8 Sprains and strains of other specified sites of sacroiliac region
- 846.9 Sprains and strains, unspecified site of sacroiliac region
- 847.2 Sprains and strains, lumbar
- 847.3 Sprains and strains, sacrum
- 847.4 Sprains and strains, coccyx
- 847.9 Sprains and strains, unspecified site of back
- 922.3 Contusion of back
- 922.31 Contusion of back, excludes interscapular region
- 953.2 Injury to lumbar root
- 953.3 Injury to sacral root

Lumbar-Sacral Spine: Herniated Disc/Radiculopathy:

- 722.1 Displacement of thoracic or lumbar intervertebral disc without myelopathy
- 722.10 Displacement of lumbar intervertebral disc without myelopathy
- 722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
- 722.70 Intervertebral disc disorder with myelopathy, unspecified region
- 722.73 Intervertebral disc disorder with myelopathy, lumbar region
- 728.0 Disorders of muscle, ligament and fascia
- 739.0 Non allopathic lesions – not elsewhere classified
- 953.3 Injury to sacral root

The following ICD-9-CM supplemental classification of external causes of injury may be used in addition to the specific diagnostic codes noted above and on each Care Path: E 810 through E 819, selected E 820 series codes. These codes may be used to indicate cause of injury as motor vehicle accident but should not be used without an associated diagnostic code.



## Exhibit B – Diagnostic Tests Subject to Decision Point Review

- (1) Brain Audio Evoked Potential (BAEP);
- (2) Brain Evoked Potential (BEP);
- (3) Computer Assisted Tomographic studies (CT, CAT Scan)
- (4) Dynatron/Cyber Station/Cybex;
- (5) Hreflex Study;
- (6) Magnetic Resonance Imaging (MRI)
- (7) Needle EMG (EMG)
- (8) Nerve Conduction Velocity (NCV)
- (9) Somatosensory Evoked Potential (SSEP)
- (10) Sonogram / Ultrasound
- (11) Visual Evoked Potential / Visual Evoked Response (VEP/VER)
- (12) Any of the following “diagnostic tests” when not otherwise excluded from coverage under Exclusion C of the NJSI policy.
  - a. Brain Mapping;
  - b. Doppler Ultrasound;
  - c. Electroencephalogram (EEG);
  - d. Sonography;
  - e. Thermography / thermograms;
  - f. Videofluoroscopy
- (13) Any other “diagnostic test” that is subject to the requirements of our Decision Point Review / PreCertification Plan by New Jersey law or regulation.



---

## Exhibit C – Services Requiring Pre-certification

1. Nonemergency inpatient and outpatient hospital care.
2. All nonemergency surgical procedures.
3. Durable medical equipment (including orthotics and prosthetics) costing greater than \$50, or rental greater than 30 days
4. Extended care rehabilitation facilities
5. Home health services.
6. Infusion therapy
7. Outpatient psychological/psychiatric services and testing.
8. All physical, occupational, speech, cognitive or other restorative therapy, or body part manipulation including Manipulation Under Anesthesia, except that provided for Identified Injuries in accordance with Decision Point Review
9. All pain management services, except that provided for Identified Injuries in accordance with Decision Point Review
10. All nonemergency diagnostic testing services, except those provided for Identified Injuries in accordance with Decision Point Review
11. Nonemergency dental restoration

## Exhibit D – IME Requirements under N.J.A.C. 11:34.7(e)

The insurer shall notify the injured person or his or her designee that a physical examination is required to determine the medical necessity of further treatment, diagnostic testing or durable medical equipment. An insurer shall include reasonable procedures for the notification of the injured person and the treating medical provider where reimbursement of further treatment, diagnostic testing or durable medical equipment or testing will be denied for failure to appear at scheduled medical examinations.

- The appointment for the physical examination shall be scheduled within seven calendar days of receipt of the notice unless the injured person agrees to extend the time period.
- The medical examination shall be conducted by a provider in the same discipline as the treating provider.
- The medical examination shall be conducted at a location reasonably convenient to the injured person.
- The injured person, upon the request of the insurer, shall provide medical records and other pertinent information to the provider conducting the medical examination. The requested records shall be provided at the time of the examination or before.
- The insurer shall notify the injured person, or his or her designee and the treating medical provider whether it will reimburse for further treatment, diagnostic tests or durable medical equipment as promptly as possible but in no case later than three business days after the examination.
- 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 upon request.

Insurers may include in their decision point review plan a procedure for the denial of reimbursement for treatment, diagnostic testing or durable medical equipment after repeated unexcused failure to attend a scheduled physical examination. The procedure shall provide for adequate notification of the insured and the treating provider of the consequences of failure to attend the examination.

### Consequences of Unexcused Failure to Attend IMEs

The EIP (Eligible Injured Person) is expected to attend each examination as scheduled by us or our Plan Administrator.

Failure of an EIP to attend a scheduled examination without a minimum of 3 business days notice to the Plan Administrator shall constitute an **unexcused** failure to attend.

Failure of an EIP to attend a scheduled examination will be considered **excused** if the EIP notifies the Plan Administrator at least 3 business days prior to the examination date and reschedules the appointment for a date, not to exceed 35 calendar days from the date of the original appointment.

If an EIP has an otherwise **excused** failure to attend a scheduled examination and does not reschedule the appointment within 35 calendar days of the original appointment date, the failure to attend shall be deemed **unexcused**.

If an EIP reschedules an examination for a date more than 35 calendar days from the date of the original appointment, any failure to attend the rescheduled appointment will be **unexcused**.

If an EIP attends a scheduled examination, but fails to supply all requested medical records, test results, diagnostic imaging films and other pertinent materials; and proper photo identification it shall be deemed an **unexcused** failure to attend the examination and the examination will not take place.

If an EIP has more than one **unexcused** failure to attend a scheduled examination, notification will be sent to the EIP or his/her representative and all known treating providers advising that payment for all treatment, diagnostic testing, prescription drugs, and durable medical equipment provided on or after the date of notification and relating to the diagnosis code(s) and/or corresponding family of codes associated with the DPR/PreCertification request that necessitated scheduling of the examination will be denied.

In such cases, no future treatment, diagnostic testing, prescription drugs, or durable medical equipment associated with the relevant diagnosis code(s) will be reimbursable under our policy.



---

## Exhibit E – List of Diagnostic Tests Applicable to Voluntary Network Services

- Magnetic Resonance Imaging (MRI)
- Computer Assisted Tomography (CT/CAT Scans)
- Needle Electromyography (needle EMG) \*
- Somatosensory Evoked Potential (SSEP)\*\*
- Visual Evoked Potential (VEP)\*\*
- Brain Audio Evoked Potential (BAEP)\*\*
- Brain Evoked Potential (BEP)\*\*
- Nerve Conduction Velocity (VEP)\*\*
- Hreflex Study\*\*
- Electroencephalogram (EEG)\*\*

\* except when performed by the treating physician.

\*\* except when performed by the treating physician in conjunction with a Needle EMG.

## ATTENDING PROVIDER TREATMENT PLAN

 INITIAL SUBMISSION

 FOLLOW-UP SUBMISSION

TYPE (OR PRINT LEGIBLY)			CLAIM #:	DATE SUBMITTED	Month	Day	Year
<b>PATIENT INFORMATION</b>				<b>POLICYHOLDER INFORMATION (if different)</b>			
1. PATIENT'S NAME Last   First   Initial			12. DATE OF ACCIDENT	15. POLICYHOLDER'S NAME Last   First   Initial			
2. PATIENT'S ADDRESS (No., Street)			13. IS PATIENT'S CONDITION RELATED TO:  A. EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO  B. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO  C. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	16. POLICYHOLDER'S ADDRESS (No.; Street)			
3. CITY	4. STATE			17. CITY			18. STATE
5. ZIP CODE	6. TELEPHONE # (Include Area Code)		14. IS PATIENT UNABLE TO WORK?  <input type="checkbox"/> NO <input type="checkbox"/> YES	19. TELEPHONE # (Include Area Code)		20. ZIP CODE	
7. PATIENT BIRTHDATE	8. SEX <input type="checkbox"/> M <input type="checkbox"/> F	9. S.S. NUMBER		21. RELATIONSHIP TO PATIENT			
10. INSURANCE COMPANY							
11. POLICY NUMBER							
<b>PROVIDER INFORMATION</b>							
22. NAME OF TREATING PROVIDER Last   First   Initial			23. TAX I.D. NUMBER	24. SPECIALTY		25. FACILITY OR OFFICE NAME	
26. FACILITY/OFFICE ADDRESS (No.; Street)			27. CITY		28. STATE	29. ZIP CODE	
30. TELEPHONE # (Include Area Code)		31. EMAIL ADDRESS		32. FAX # (Include Area Code)		33. INITIAL DATE OF TX	
						34. DATE OF LAST VISIT	
35. PATIENT MEDICAL HISTORY. HAS PATIENT EVER HAD ANY OF THE FOLLOWING SERVICES? CHECKMARK THOSE APPLICABLE BELOW. (*NOTE-ALL BOXES CHECKED REQUIRE A BRIEF DESCRIPTION OF SERVICE AND DATE PROVIDED ON SEPARATE ATTACHMENT)							
<input type="checkbox"/> ALL MEDICATION <input type="checkbox"/> MRI <input type="checkbox"/> SURGERY <input type="checkbox"/> X-RAY <input type="checkbox"/> DIAGNOSTICS TESTING <input type="checkbox"/> OTHER							
36. PRIMARY DIAGNOSIS (ICD-9)		37. SECONDARY DIAGNOSIS (ICD-9)		38. ADDITIONAL DIAGNOSIS (ICD-9)		39. ADDITIONAL DIAGNOSIS (ICD-9)	
<b>PROPOSED COURSE OF TREATMENT AS IT RELATES TO THIS MVA</b>							
40. DATE(S) OF TREATMENT REQUESTED FROM   TO			41. CHECK APPROPRIATE CARE PATH (if applicable)				
			<input type="checkbox"/> CP1 <input type="checkbox"/> CP2 <input type="checkbox"/> CP3 <input type="checkbox"/> CP4 <input type="checkbox"/> CP5 <input type="checkbox"/> CP6				
42. REQUEST FOR SERVICES : CPT / HCPCS / NDC CODES							
(Use left box for single codes or left and right box for a range of codes)				FREQUENCY (Times per visit)	FREQUENCY (Visits per week)	DURATION (Number of weeks)	TOTAL UNITS
42. CHECKMARK ATTACHMENTS BELOW. (*NOTE-ALL SUPPORTING DOCUMENTS CHECKED <b>MUST</b> BE PROVIDED ON SEPARATE ATTACHMENT)							
<input type="checkbox"/> SOAP NOTES <input type="checkbox"/> PROGRESS NOTES <input type="checkbox"/> TEST RESULTS <input type="checkbox"/> MEDICAL HISTORY <input type="checkbox"/> PRESCRIPTIONS <input type="checkbox"/> OTHER							

### FRAUD PREVENTION-NEW JERSEY WARNING

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

#### PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED AND REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

43.

SIGNATURE OF PROVIDER

DATE