Hanover Insurance Company
440 Lincoln St.
Worcester, MA 01653

Date:

RE: (Patient Name)
(Patient Address)

SSN:
Claim Number:
Date of Accident:

Dear Dr. ____________________:

The patient noted above was involved in a motor vehicle accident (MVA). We have been informed that he/she will receive treatment with you. Pursuant to N.J.A.C. 11:3-4, you are required to provide us with notification for certain tests you may order, or services you may perform on the patient. As described more fully below, this notification is provided in connection with Decision Point Review and Pre-certification. Consolidated Services Group, Inc. (hereinafter referred to as CSG) has been contracted by Hanover Insurance Co. to be the Utilization Review Organization involved with the Decision Point Review and Pre-certification process.

Please note, Decision Point Review and Pre-certification requirements do not apply until after the 10th calendar day following the MVA and do not apply to Emergency Care. This provision should not be construed so as to require reimbursement of tests and treatment that are not medically necessary.

DECISION POINT REVIEW

Pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance 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 the treatment be evaluated at certain intervals called *Decision Points*. On the Care Paths, Decision Points are represented by hexagonal boxes. At decision points you must provide us information about further treatment you intend to provide (*Decision Point Review*). In addition, the administration of any test on the list in Exhibit B also requires *Decision Point Review* regardless of the diagnosis. The *Care Paths* and accompanying rules are available on the internet at the State of New Jersey Department of Banking and Insurance website at www.nj.gov/dobi/aicrapg.htm, or by contacting Consolidated Services Group, Inc., (CSG) at 877-258-CERT (2378). If you fail to request decision point review where required, or fail to submit clinically supported findings that support the request, payment of your bills may be subject to a penalty co-payment of 50% even if the services are determined to be medically necessary.

MANDATORY PRE-CERTIFICATION

You are required to obtain pre-certification for all services itemized in Exhibit B (attached). If you fail to request pre-certification where required or fail to submit clinically supported findings that support the request, payment of your bills may be subject to a penalty co-payment of 50% even if the services are determined to be medically necessary. You are encouraged to maintain communication with CSG's Utilization Review Department on a regular basis as Decision Point Review and Pre-certification requirements may change.

Pursuant to N.J.A.C. 11:3-4.5, the following tests are prohibited under any circumstances:

Spinal diagnostic ultrasound

Iridology

- Reflexology
- Surrogate arm mentoring
- Surface electromyography (surface EMG)
- Mandibular tracking and stimulation
- X-ray digitization and/or computer assisted radiographic mensuration
- Any other diagnostic test that is determined by New Jersey law or regulation to be ineligible for personal injury protection coverage

Pursuant to N.J.A.C. 11:3-4.5(f) and 13:30-8.22(b), Hanover will not provide reimbursement for the following diagnostic tests which have been identified by the New Jersey State Board of Dentistry as failing to yield data of sufficient volume to alter or influence the diagnosis or treatment plan employed to treat temporomandibular joint disorder (TMJ/D):

- Mandibular tracking
- Surface EMG
- Sonography
- Doppler ultrasound
- Needle EMG
- Electroencephalogram ("EEG")
- Thermograms/thermographs
- Videofluoroscopy
- Reflexology

Hanover will also not provide reimbursement for the following:

- Laboratory testing services from any entity that is not certified by the Department of Health and Human Services ("HHS").

- Prescription medications, drugs and biologicals that are not approved by the USFDA.

- Compound prescription medications, drugs and/or biologicals that, as compounded, are not approved by the USFDA, including but not limited to, compounds that may have in their formulary one or more medications, drugs and/or biologicals individually approved by the USFDA.

VOLUNTARY PRE-CERTIFICATION

You are encouraged to participate in a *Voluntary Pre-certification* process by providing CSG's Utilization Review Department with a comprehensive treatment plan for both identified and other injuries. CSG 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 Pre-certification process, the bills you submit, when consistent with pre-certified services, you will be paid so long as they are in accordance with the PIP medical fee schedule set forth in N.J.A.C. 11:3-29.6.

HOW TO SUBMIT DECISION POINT REVIEW AND PRECERTIFICATION NOTIFICATIONS

In order to complete a review, you are required to provide CSG with any past medical history that is available. It is also required that you provide the diagnosis, prognosis, all x-ray and other test results that may have been completed, and documentation of all treatment provided to date. Please indicate any tests or treatment you anticipate over the next 30 calendar days.

All Decision Point Review and Pre-certification requests must be submitted using the Attending Provider Treatment Plan form. A copy of this form can be found at the Department's website at www.state.nj.us/dobi/pipinfo/aicrapg.htm or through CSGs website http://www.csg-inc.net/nj_auto_plans.htm or by contacting CSG at (877) 258-CERT (2378).

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

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 CSG via fax at (856) 910-2501 or mail to the following address: CSG, Inc., 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619, ATTN.: Pre-Certification Department. CSG's phone number is (877) 258-CERT (2378).

The review of decision point review and pre-certification notifications will be completed within three (3) business days of receipt of the necessary information. Notice of certification will be made to your office by Telephone, fax and/or confirmed in writing. If we fail to notify you within three (3) business days, you may continue with the test 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 the results become available. Any decision to deny a decision point review or pre-certification request based on medical necessity will be the determination of a physician or dentist.

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 CSG receives the submission. CSG 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, CSG's decision is due no later than close of business Monday, February 11, 2013.

REVIEW OUTCOMES

- Requested service is certified.
- In the event there is insufficient information that does not support the requested service, a status pending letter or administrative denial will be issued and will continue until sufficient documentation is received to evaluate the request for the diagnostic test or service.
- If there is a need to amend the requested services (either frequency, duration, intensity or place of service or treatment), your office will be notified by either telephone, fax and/or confirmed in writing.
- In the event the request cannot be certified, your office will be notified by telephone, fax and/or confirmed in writing. When needed, a medical professional will be available to discuss the case with you.
- Pursuant to N.J.A.C. 11:3-4 and the patient's/insured's policy: Failure to request decision point review or pre-certification where required or failure to submit clinically supported findings that support the request can result in a 50% penalty co-payment for treatment or tests that are determined to be medically necessary.
- In the event the notice and supporting materials are insufficient to authorize or deny reimbursement for further services, it may require that the patient/insured undergo an Independent Medical Examination.

INDEPENDENT MEDICAL EXAMINATION

If it is requested the patient/insured undergo an Independent Medical Examination (IME) during the decision point review/pre-certification process, you will be notified of the date, time, and location of the exam. The IME will be scheduled within seven (7) calendar days of our receipt of the Attending Provider Treatment Plan form (unless the patient/insured agrees to extend the time period); with a provider in the same discipline; and at a location reasonably convenient to the patient/insured. At our request, the patient/insured may be required to provide medical records, x-rays, and other pertinent information at or before the time of the IME. You will be notified of the results of the IME within 3 business days after attendance of the IME. If the examining provider prepares a written report, a copy of the report is available upon request.

IME PROVISIONS

If the patient/insured has two (2) or more unexcused failures to attend the scheduled exam, notification will be immediately sent to the patient/insured, and all health care providers treating for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form. The notification will place the patient/insured 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.

Failure of the patient/insured to provide requested medical records, x-rays, or other pertinent information at or before the IME will be considered an unexcused failure to attend the IME.

ADDITIONAL PENALTY CO-PAYMENT

N.J.A.C. 11:3-4.4(e) provides for the production of information from the insured regarding the facts of the accident, the nature and cause of the injury, the diagnosis and anticipated course of treatment. This information may be required promptly after the accident and periodically thereafter. An additional co-payment penalty of 25% may apply if the information is received 30 or more business days after the accident or 50% when the information is received 60 or more business days after the accident.

INTERNAL APPEALS PROCESS

If CSG fails to certify a request, the clinical rationale for this determination is available to you and/or your health care provider upon written request. If your health care provider would like to have the decision reconsidered, they can participate in CSG's internal appeals 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. All forms must be fully completed and include the minimum associated documents required. 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 or 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 CSG 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 insured 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(i.e.: Peer Review, Independent Medical Exam, Medical Director Review, etc....) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

Post-service: 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 CSG 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 insured 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(i.e.: Peer Review, Independent Medical Exam, Medical Director Review, etc....) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

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 NETWORK SERVICES

Please note that your patient's policy includes a voluntary Utilization Program for Prescription Drugs, Durable Medical Equipment over $50, Ambulatory Surgical Care, Diagnostic Imaging and Electro-diagnostic Testing. The network for diagnostic imaging applies to MRI's and CAT scans. The network for electro-diagnostic tests applies to the electro-diagnostic tests listed in N.J.A.C. 11:3-4.5(b) 1 through 3, except when performed by the treating physician. A 30% co-payment ($10 for prescription drugs) is applicable to these services. The services are paid in full when an eligible injured person voluntarily uses a provider from the network. **There is no co-payment penalty to the injured party when an eligible injured person voluntarily uses a provider from the following networks:**

Progressive Medical, LLC DBA Optum for prescription drugs and DME with a cost or monthly rental over $50 888-764-4844

Horizon Casualty Service for Ambulatory Surgical Care: 800-985-7777

Horizon Casualty Service, Inc provides access to the following in network diagnostic Centers. Appointments should be scheduled through:

Raytel: 800-453-0574 Monday- Friday 7:30AM to 7:30PM EST

One Call Medical: 800-872-2875 or 800-418-5058 Monday – Friday 8:00AM – 8:00PM EST

ASSIGMENT OF BENEFITS

These benefits shall not be assignable except to providers of services. Any such assignment is not enforceable unless you agree to be subject to the requirements of our Decision Point Review Plan, including Pre-certification, utilizing CSG's internal Appeal Process for reconsideration of denials of certification, and submit disputes not resolved through the internal Appeal Process to alternate dispute resolution pursuant to N.J.A.C. 11:3-5. In addition, you must agree to hold an "insured" or "eligible person" harmless for any penalty imposed by us for your failure to adhere to the requirements of our Decision Point Review Plan, including Pre-certification.

The staff at CSG is available to you and your patient, to answer questions and assist with the Decision Point Review and Pre-certification process.

Thank you for your continued cooperation.

Sincerely,
Hanover Insurance Company

EXHIBIT A

Identified Injuries

722.0	Displacement of cervical intervertebral disc without myelopathy
722.1	Displacement of thoracic or lumbar intervertebral disc without myelopathy
722.10	Displacement of lumbar intervertebral disc without myelopathy
722.11.1	Displacement of thoracic intervertebral disc without myelopathy
722.2	Displacement of intervertabral disc, site unspecified, without myelopathy
722.70	Intervertebral disc disorder with myelopathy, unspecified region
722.71	Intervertebral disc disorder with myelopathy, cervical region
722.72	Intervertebral disc disorder with myelopathy, thoracic region
722.73	Intervertebral disc disorder with myelopathy, lumbar region
728.0	Disorders of muscle, ligament and fascia
728.85	Spasm of muscle
739.0	Non-allopathid lesions, not elsewhere classified
739.1.1.1	Somantic dysfunction of cervical region
739.1.1.2	Somantic dysfunction of thoracic region
739.3	Somantic dysfunction of lumbar region
739.4	Somantic dysfunction of sacral region
739.8	Somantic dysfunction of rib cage
845.0	Sprains and strains of sacroiliac region
846.1	Sprains and strains of lumbosacral (joint) (ligament)
846.2	Sprains and strains of sacrospinatus (ligament)
846.3	Sprains and strains of sacrotuberous region
846.8	Sprains and strains of other specified sites of sacroiliac region
846.9	Sprains and strains, unspecified site of sacroiliac region
847.0	Sprains and strains of neck
847.1	Sprains and strains, thoracic
847.2	Sprains and strains, lumbar
847.3	Sprains and strains, sacrum
847.4	Sprains and strains, coccyx
847.9	Sprains and strains of back, unspecified site
922.3	Contusion of back
922.31	Contusion of back, excludes interscapular region
922.33	Contusion of back, interscapular region
953.0	Injury to cervical root
953.2	Injury to lumbar root
953.3	Injury to sacral root

*(The injuries identified on Exhibit A are diagnostic codes associated with Care Paths 1 through 6, as identified in Appendix B of the NJ Administrative Code, and are not intended to be the exclusive list used for Care Path injuries.)

THE HANOVER INSURANCE COMPANY

EXHIBIT B

Diagnostic Tests that are subject to Decision Point Review:

1. Brain audio evoked potentials (BAEP);
2. Brain evoked potentials (BEP);
3. Computer assisted tomograms (CT, CAT scan);
4. Dynatron/cybex station/cybex studies;
5. Electroencephalogram (EEG);
6. H-reflex studies;
7. Magnetic resonance imaging (MRI);
8. Needle electromyography (EMG);
9. Nerve conduction velocity (NCV);
10. Somatosensory evoked potential (SSEP);
11. Sonogram/ultrasound;
12. Videofluroscopy;
13. Visual evoked potential (VEP);
14. Bone scans;
15. Myelograms;
16. Brain mapping;
17. Thermography.

Any other diagnostic test that is subject to the requirements of our Decision Point Review Plan by New Jersey law or regulation.

The following services require pre-certification:

1.	Non-emergency in-patient and out-patient hospital care (including the appropriateness and duration of the hospital stay);
2.	Non-emergency surgery (performed in a hospital, freestanding surgical center, office, etc.);
3.	Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of $50;
4.	Extended care and rehabilitation;
5.	Home health care;
6.	Infusion therapy;
7.	Outpatient psychological/psychiatric testing and/or services;
8.	All physical, occupational, cognitive, speech or other restorative therapy, or body part manipulation except that provided for Identified Injuries in accordance with Decision Point Review; and,
9.	All pain management services except that provided for Identified Injuries in accordance with Decision Point Review;
10.	Non-emergency dental restoration;
11.	Non-emergency dental services including temporomandibular disorders or any oral facial syndrome.
12.	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