Fitchburg Mutual Insurance Company
222 Ames Street
Dedham, MA 02026
800-688-1825

DECISION POINT REVIEW PLAN REQUIREMENTS

Important information about your no-fault medical coverage and reimbursement. Please read this information carefully and share it with your treating health care providers.

In 1998 New Jersey enacted the Automobile Insurance Cost Reduction Act and as a result there are established obligations which you must satisfy for coverage of medically necessary treatment, diagnostic testing and durable medical equipment arising from injuries sustained in an automobile accident. During the course of your claim, you may be contacted by our PIP vendor, **Consolidated Services Group, Inc. (CSG)**, as it relates to obligations you have while receiving medical treatment for your injuries and any subsequent bills. This communication from CSG may include, but is not limited to, information pertaining to your obligation to attend an independent medical examination (IME). Please be on notice that the failure to abide by the following obligations defined herein and as defined in your Policy of Insurance, may affect the authorization for medical treatment, diagnostic testing and durable medical equipment.

This document serves as Fitchburg Mutual Insurance Company's (Fitchburg) Decision Point Review and Pre-Certification Plan in accordance with N.J.A.C. 11:3-4.7 and N.J.A.C. 11:3-4.8.

CSG is a PIP vendor as defined in N.J.A.C. 11:3-4.2. CSG's contact information is as follows:

CSG, Inc.
300 American Metro Blvd, Suite 170
Hamilton, NJ 08619
Telephone: 877-258-2378
Fax: 856-910-2501
Website: www.csg-inc.net

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

Fitchburg will provide all injured claimants seeking PIP benefits with copies of our DPR Plan (this document) as well as a question and answer brochure upon notice of a potential claim. These documents will outline all key elements/requirements/ responsibilities of the plan as required in N.J.A.C. 11:3-4.7(d)1-9. This information will also be made available on the World Wide Web @ CSG's site www.csg-inc.net.

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

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

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

The definition of days is as follows: “Days” means calendar days unless specifically designated as business days.

1. A calendar and business day both end at the time of the close of business hours (7:00 PM EST Monday through Friday (excluding legal holidays).

2. In computing any period of time designated as either calendar or business days, the day from which the designated period of time begins to run shall not be included. The last day of a period of time designated as calendar or business day is to be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday or legal holiday.

3. Example: Response to a properly submitted provider request is due back no later than 3 business days from the date CSG receives the submission. CSG receives an Attending Provider Treatment Plan Form by facsimile transmission dated 1:00 PM EST on Wednesday, February 6, 2017. Day one of the 3-buisness day period is Thursday, February 7, 2017. Since the 3rd day would be Saturday, February 9, 2017, CSG’s decision is due no later than close of business Monday, February 11, 2017.

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

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

If the need arises for CSG to utilize an independent medical exam during the decision point review/pre-certification process, the guidelines in accordance to 11:3-4.7(e) 1-7

will be followed. This includes but is not limited to: prior notification to the injured person or his or her designee, scheduling the exam within seven calendar days of the receipt of the attending physicians treatment plan (unless the injured person agrees to extend the time period) through a detailed scheduling letter sent to the injured person or his or her designee(see example under correspondence section), having the exam conducted by a provider in the same discipline, scheduling the exam at a location reasonably convenient to the injured person, and providing notification of the decision within three business days after attendance of the exam on a Care Plan Evaluation letter.

If the injured person has more than one unexcused failures to attend the scheduled exam, notification will be immediately sent (on a Care Plan Evaluation letter) to the injured person or his or her designee, and all providers treating the injured person for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form. The notification will place the injured person on notice that all future treatment, diagnostic testing or durable medical equipment required for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form will not be reimbursable as a consequence for failure to comply with the plan.

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

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

Prior to making a request for alternate dispute resolution, all appeals must be initiated using the forms established by the NJ Department of Banking and Insurance. The minimum required information (identified by form section number) is as follows:

KEY DATES (sections 1-2) CLAIM INFO (sections 3-5) PATIENT INFO (sections 6-7 and 9-13) PROVIDER/FACILITY INFO (sections 14-25) DOCUMENTS INCLUDED INFO (section 29 indicated with asterisk) PRE-SERVICE APPEALS ISSUES INFO (sections 30-31, and 32, 33, or 34) POST-SERVICE APPEALS ISSUES INFO (sections 30-31, 33 and/or 38 and 34-36 if completing section 38) PRE-SERVICE SIGNATURE INFO (sections 35-36) POST-SERVICE SIGNATURE INFO (sections 39-40). Failure to follow these requirements will be considered an incomplete submission and will result in an administrative denial. This incomplete submission does not constitute acceptance within the required timeframes for Pre-service and Post-service appeals.

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

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

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

Pre-service: an appeal of the denial or modification of a decision point review or precertification request prior to the performance or issuance of the requested medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment on the grounds of medical necessity.

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 insurer or its designated vendor to the provider who submitted the appeal no later than 14 days after receipt of the pre-service appeal form and any supporting documentation. If it's determined that the new information submitted with the appeal requires the need of an expert report or addendum to an expert report (ie: Peer Review, Independent Medical Exam, Medical Director Review, etc ...) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

Post-service: an appeal subsequent to the performance or issuance of the services and/or what should be reimbursed.

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

A post-service appeal shall be submitted at least 45 days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in Superior Court.

Decisions on post-service appeals shall be issued by the insurer or its designated vendor to the provider who submitted the appeal no later than 30 days after receipt of the appeal form and any supporting documentation. If it's determined that the new information submitted with the appeal requires the need of an expert report or addendum to an expert report (ie: Professional Code Review, Medical Bill Audit Report, UCR Analytical Analysis, etc ...) to properly respond to the appeal, an additional 10 days will be added to the response time requirement.

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

If a claimant or provider retains counsel to represent them during the Internal Appeal Procedures, they do so strictly at their own expense. No reimbursement will be issued for counsel fees or any other costs, regardless of the outcome of the appeal.

In accordance with N.J.A.C. 11:3-4.8(b) the plan includes a voluntary utilization program for:

1. Magnetic Resonance Imagery
2. Computer Assisted Tomography
3. The electro diagnostic tests listed in N.J.A.C. 11:3-4.5(b)1 through 3 except for needle EMGs, H-reflex and nerve conduction velocity (NVC) tests performed together by the treating physician
4. Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of $75.00
5. Services, equipment or accommodations provided by an ambulatory surgery facility
6. Prescription Drugs

When one of the above listed services, tests, equipment, or prescription drugs is requested through the decision point review/pre-certification process, a detailed care plan evaluation letter containing the outcome of the review is sent to the injured person or his or her designee, and the requesting provider. In addition the notice will include how to acquire a list of available preferred provider networks to obtain the medically necessary services, tests, equipment, or prescription drugs requested. In the case of Prescription Drugs, a pharmacy card will be issued that can be presented at numerous participating pharmacies. A list of these participating pharmacies will be made available at the time of card issuance. In accordance with N.J.A.C.11:3-4.4(g), failure to use an approved network will result in a co-payment of 30 % (in addition to any deductible or copayment that applies under the policy) of the eligible charge.

In addition to securing a list of preferred provider networks through the process outlined in the paragraph above, the injured person or his or her designee, and the requesting provider can visit CSG's website @ www.csg-inc.net, contact CSG by phone @ (877) 258-CERT (2378), via fax @ (856) 910-2501, or in writing @ 300 American Metro Blvd. Suite 170, Hamilton, NJ 08619.

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