S t a t e F a r m I n d e m n i t y C o m p a n y
S t a t e F a r m G u a r a n t y I n s u r a n c e C o m p a n y

Dear Provider:

Medical services related to automobile accidents and covered by State Farm Insurance are subject to Decision Point Review as required under the laws of New Jersey or Pre-certification as outlined in State Farm's Decision Point Review Plan (Plan) approved by the New Jersey Department of Banking and Insurance. For your review, we are enclosing information including a Decision Point Review Plan summary.

Failure to comply with the requirements of the Plan will result in the application of an additional co-payment penalty as outlined in the enclosed material.

Also included in the enclosed information is a Conditional Assignment of Benefits (CAOB) form for you and your patient to sign. Acceptance of assignment of benefits will be conditioned on State Farm's receipt of a properly executed form, your acceptance of, and compliance with, the conditions stipulated therein. **Please review the CAOB carefully as it has been updated with additional conditions.** These conditions apply to claims, such as this, with a date of loss on or after November 1, 2011**. Providers who sign State Farm's Conditional Assignment of benefits for this claim agree to comply with a request to (i.) submit to an examination under oath, and (ii.) provide the Company with any other pertinent information/documentation that it requests.**

With regard to the Plan requirements, State Farm recognizes a treatment plan can only be developed after an initial (new patient) office visit is completed. While you are not required to submit this initial (new patient) office visit for Decision Point Review/Pre-certification, this visit may be subject to retrospective review of its causal relationship to the loss. Please keep in mind; all follow up (established patient) office visits subject to the requirements of the Plan must be submitted to State Farm's vendor, Consolidated Services Group (CSG). Failure to pre-certify the (established patient) office visits subject to the State Farm Plan will result in the application of a 50% co-payment penalty.

In addition, per N.J.A.C. 11:3-29.4(m), certain CPT codes have been identified as subject to a maximum daily allowance of $99. While these codes may be evaluated as medically necessary as part of your treatment plan, other providers may also be submitting treatment plans with the same range of CPT codes. Regardless of the number of providers, the $99 maximum daily allowance will apply to reimbursement of these medically necessary services performed on the same day.

The Plan includes the following forums for dispute resolution; Pre-Service Appeals, Post-Service Appeals and Personal Injury Protection Dispute Resolution set forth in N.J.A.C. 11:3-5. These forums are also described in the enclosed summary.

Providers who retain counsel to assist them in the Pre-Service Appeal or Post-Service Appeal process do so strictly at their own expense. State Farm will not reimburse providers for their counsel fees or any other costs regardless of the outcome of the process.

For complete information, you can request a copy of the Plan from State Farm or access a copy via the internet at www.statefarm.com/insurance/service_center/njpip.asp.

Please carefully review the enclosed information. Feel free to contact us for additional information or clarification of our Decision Point Review Plan requirements.

Sincerely,

State Farm Indemnity Company

Enclosure: Decision Point Review Plan Summary
Conditional Assignment of Benefits

NJ Form DPRP Letter 12-15-13

State Farm Indemnity Company State Farm Guaranty Insurance Company

Pursuant to State Farm's Decision Point Review Plan (Plan), approved by the New Jersey Department of Banking and Insurance, and State Farm's automobile insurance policy, certain requirements must be met in order for medical expense benefits to be eligible for payment without application of a penalty. The Plan requires the medical necessity of certain nonemergency diagnostic tests, medical treatments, procedures, services and goods be pre-certified or reviewed at established "decision points." Additionally, these tests, treatment, services, or procedures must be consistent with clinically supported findings in order to be eligible for payment. The Plan consists of a Medical Services Review, Decision Point Review and Precertification. The following is a summary of the Plan; a complete copy of the Plan is available at State Farm's website, www.statefarm.com/insurance/service_center/njpip.asp.

Decision Point Review Plan Summary

Essential Procedures

***Medical Services Review*:** A Medical Services Review (MSR) is required for all claims to collect essential claim information, the facts of the accident, the nature and cause of the injury, the diagnosis and the anticipated course of treatment. An MSR is conducted upon initial notification of the claim to State Farm. The insured must provide this information as promptly as possible. Failure to provide this information or providing it more than 30 days after the accident shall result in the application of a co-payment penalty.

***Decision Point Review*:** Decision Point Review will be conducted in accordance with the Care Path Treatment Protocols and diagnostic tests as defined by New Jersey law. At each Decision Point, the medical provider is required to consult with State Farm's vendor for Decision Point Review. Decision Point Review applies to the following:

a) All treatment of accidental injury to the spine and back for ICD Codes specified in the Care Paths in the Appendix of N.J.A.C. 11:3 4.1, et seq.
b) All diagnostic tests identified in N.J.A.C. 11:3 4.5 (b) for both identified and all other injuries.

A complete copy of the Care Path Treatment Protocols is available at the NJ Department of Banking and Insurance website, www.state.nj.us/dobi/pipinfo/aicrapg.htm.

***Pre-Certification*:** For diagnostic tests, treatments, services, durable medical goods and activities identified below, the patient's medical provider is required to submit prior notification to State Farm's vendor. Pre-certification applies to the following:

a) non-emergency inpatient and outpatient hospital care;
b) non-emergency surgical procedures;

c) outpatient care, including follow-up evaluations, 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;
d) temporomandibular disorders; any oral facial syndrome;
e) carpal tunnel syndrome;
f) outpatient psychological/psychiatric testing and/or services;
g) home health care;
h) durable medical goods with an aggregate cost or monthly rental in excess of $75.00, including durable medical equipment and associated supplies, prosthetics and orthotics;
i) 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 in excess of $75.00, including but not limited to the following:
    1. vehicles,
    2. modifications to vehicles,
    3. durable goods,
    4. furnishings,
    5. improvements or modifications to real or personal property,
    6. fixtures,
    7. spa/gym memberships,
    8. recreational activities and trips,
    9. leisure activities and trips,
j) non-emergency medical transportation with a round trip transportation expense in excess of $75.00; k) nonemergency dental restoration;
l) physical, occupational, speech, cognitive or other restorative therapy, or body part manipulation, including follow up evaluations by the referring physician, except that provided for identified injuries in accordance with Decision Point Review; and
m) pain management treatment except that provided for identified injuries in accordance with Decision Point Review, including but not limited to the following:
    1. acupuncture,
    2. nerve blocks,
    3. manipulation under anesthesia,
    4. anesthesia when performed in conjunction with invasive techniques,
    5. epidural steroid injections,
    6. radio frequency/rhyzotomy,
    7. narcotics, when prescribed for more than three months;
    8. biofeedback,
    9. implantation of spinal stimulators or spinal pumps, and
    10. trigger point rejections
n) Ambulatory Surgical Center

Decision Point Review/Pre certification requirements will not apply to diagnostic tests, treatments, or durable medical goods performed or obtained within 10 days of the accident or administered during emergency care. However, such care may be reviewed retrospectively and must be medically necessary and as a result of a covered automobile accident in order to be reimbursable.

Vendor: State Farm has selected Consolidated Services Group (CSG) to be its independent contractor for the medical evaluations concerning the Plan. CSG Medical Reviewers will be available from 7:00 a.m. to 7:00 p.m. Monday-Friday to respond to provider inquiries or requests by phone at 1-877-258-2378. Voice mail and pager contact with CSG on-call personnel will be activated for messages received on Saturdays.

Written Decision Point Review/Pre-certification requests must be submitted on the Attending Provider Treatment Plan form, approved by the NJ Department of Banking and Insurance and sent with supporting documentation to:

CSG-Pre-certification Department
300 American Metro Blvd.
Suite 170
Hamilton, NJ 08619

Attending Provider Treatment Plan forms may also be faxed to CSG at: **(856) 910-2501**.

Copies of the Attending Provider Treatment Plan form can be requested from State Farm or can be accessed at State Farm's website or www.state.nj.us/dobi/orders/treatmentform.pdf.

The Process

Decision Point Review/Pre-certification: Requests for Decision Point Review/Pre-certification, telephonic or written, must be submitted directly to CSG with all clinically supported findings. The information will be reviewed by a Medical Reviewer and/or a Medical Director to evaluate the medical necessity of the request.

Attempts will be made to resolve telephonic requests at the time of a provider's contact with CSG. Regardless, all responses to requests for services will be communicated in writing. A Decision Point Review/Pre-certification Evaluation letter confirming CSG's evaluation will be sent to the patient and the treating provider within three (3) business days after receipt of the request. The Decision Point Review/Pre-certification letter will confirm whether or not the request was evaluated as medically necessary.

If State Farm or CSG fails to respond to a request for Decision Point Review/Pre-certification within three (3) business days, the treatment or test may proceed (without application of a co-payment penalty) until State Farm or CSG notifies the provider of the evaluation results.

If a Medical Director determines the supporting medical information is insufficient to render an opinion as to the medical necessity of the request, the scheduling of an independent medical examination may be requested (see ***Independent Medical Examinations***).

The Decision Point Review/Pre-certification evaluation is strictly a review of medical necessity by CSG on State Farm's behalf. Reimbursement for the expenses of medically necessary care is subject to the provisions of the auto insurance policy and New Jersey law including deductibles, co-payments, policy limits and the medical fee schedule. Reimbursement is also subject to a determination apart from medical necessity that the care is for injuries caused by a covered accident.

State Farm’s close of business is 7:00 PM EST Monday through Friday (excluding legal holidays). Requests must be submitted by close of business to be considered received on that business day. Requests received after close of business will be considered received on the next business day.

Internal Appeals Procedures

Under State Farm’s Conditional Assignment of Benefits, the provider shall be required to utilize the Internal Appeals process before submitting the disputes to Personal Injury Protection Dispute Resolution under N.J.A.C. 11:3-5, et seq.

To file a Pre-Service Appeal, the provider must complete and submit the Pre-Service Appeal form and any supporting documentation to CSG via fax at **(856) 910-2501** or mail at 300 American Metro Blvd, Suite 170, Hamilton, NJ 08619.

For Post Service Appeals, the provider must complete the Post Service Appeal form and select a physician to review the dispute from a list maintained by CSG. If the provider does not select a reviewing physician, one will be selected on the provider’s behalf. The appeal form and any supporting documentation must be submitted to State Farm Claims, P.O. Box

106170, Atlanta, GA 30348-6170 or by fax at (844) 218-1140. The decision by the reviewing physician is non-binding to all parties.

As per 11:3-4.7B - Requirements for insurer internal appeals procedures:

- State Farm only requires a one-level appeal procedure for each appealed issue before making a request for alternate dispute resolution in accordance with N.J.A.C. 11:3-15. That is, each issue shall only be required to receive one internal appeal review by the insurer prior to making a request for alternate dispute resolution. An appeal of the denial of a medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment on the grounds of medical necessity is a different issue than an appeal of what the insurer should reimburse the provider for that same service.
- There are two types of internal appeals and a separate and distinct form is available for each type of appeal:
    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”); and
    2. Post-service: Appeals subsequent to the performance or issuance of the services.
- Both the New Jersey PIP Pre-Service Appeal Form and the New Jersey PIP Post Service Appeal Form can be found on the NJ Department of Banking and Insurance website or at State Farm’s website, www.statefarm.com/claims/njpip.htm , or upon request from State Farm by calling 1-888-326-0152. The list of physician reviewers is available at CSG's website, www.medlogix.com , or upon request from State Farm or CSG.
- A pre-service appeal shall be submitted no later than 30 days after receipt of a written denial or modification of requested services.
- 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 pre-service appeals shall be issued by the insurer to the provider who submitted the appeal no later than 14 days after receipt of the pre-service appeal form and any supporting documentation.
- Decisions on post-service appeals shall be issued by the insurer to the provider who submitted the appeal no later than 30 days after receipt of the appeal form and any supporting documentation.
- Nothing in this section shall be construed so as to require reimbursement of services that are not medically necessary or to prevent the application of the penalty co-payments in N.J.A.C. 11:3-4.4(e), (f) and (g).

The Internal Appeals process is an attempt to resolve disputes directly between State Farm and the provider. Providers who retain counsel to assist them in the Internal Appeals process do so strictly at their own expense. State Farm will not reimburse providers for their counsel fees or any other costs regardless of the outcome of the process.

Personal Injury Protection Dispute Resolution: A PIP dispute, as defined by N.J.A.C. 11:3-5, may be submitted to Personal Injury Protection (PIP) Dispute Resolution by an injured party, the insured or the company. PIP Dispute Resolution shall be conducted in accordance with the procedures set forth in N.J.A.C. 11:3-5, including any amendments. The final determination made by the dispute resolution professional shall be binding upon the parties, but subject to vacation, modification or correction by the Superior Court in an action filed pursuant to N.J.S.A. 2A:23A-13 for review of the award.

Under State Farm's Conditional Assignment of Benefits, after exhausting the Internal Dispute Resolution process, a provider must submit any PIP dispute, as defined by N.J.A.C. 11:3-5, to PIP Dispute Resolution in accordance with this Plan.

Independent Medical Examinations: An exam scheduled pursuant to this Plan is intended to provide a timely review of proposed medical care. If a physical/mental examination of the injured person is requested pursuant to this Plan, State Farm, or its designated vendor, will notify the injured person or his or her designee of the time, date, and place of examination. A notice will also be sent to all known providers treating the injured person advising of the examination and consequences for repeated unexcused failures to attend on the part of the patient. The appointment for the physical examination will be scheduled within seven (7) calendar days of receipt of the request for Decision Point Review/Pre-certification unless the injured person agrees to extend the time period. The medical examination will be conducted by a practitioner in the same

discipline as the treating provider and at a location reasonably convenient to the injured person. Upon request of State Farm, or its designated vendor, the injured person will provide medical records and other pertinent information to the practitioner conducting the medical examination no later than at the time of the examination.

State Farm will schedule the physical/mental examination to occur during the first thirty-five (35) calendar days after CSG's receipt of the Decision Point Review/Pre-certification request.

Once the exam is attended, State Farm, or its designated vendor, will promptly notify the injured person or his or her designee and the treating provider whether the request was evaluated as medically necessary, but no later than three (3) 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 and may request one from State Farm.

Failure to attend the physical/mental examination scheduled to occur within thirty-five (35) calendar days from CSG's receipt of the Decision Point Review/Pre-certification request will be **excused** if the injured person notifies State Farm or CSG at least three (3) business days before the examination date of his or her inability to attend the exam. Another exam will then be scheduled to occur within the thirty-five (35) calendar days.

Failure to attend a physical/mental examination scheduled to occur within thirty-five (35) calendar days from CSG's receipt of the Decision Point Review/Pre-certification request will be **unexcused** if the injured person does not notify State Farm or CSG at least three (3) business days before the examination date of his or her inability to attend the exam.

Failure to attend a physical/mental examination rescheduled to occur more than thirty-five (35) calendar days from CSG's receipt of the Decision Point Review/Pre-certification request will be **unexcused**.

If the injured person has two or more unexcused failures to attend a scheduled examination, State Farm will deny payment for treatment, diagnostic testing and durable medical goods provided on or after the date of the second unexcused failure to attend. State Farm's denial will apply to treatment, diagnostic testing and durable medical goods relating to the diagnosis code(s) and corresponding family of codes associated with the Decision Point Review/Pre-certification request that necessitated the scheduling of the physical/mental examination.

In such cases, notification will be sent to the injured person or his or her designee and all known providers treating the injured person. The notification will advise that all future treatment, diagnostic testing and durable medical equipment associated with the diagnosis code(s), and corresponding family of codes, contained in the request or Attending Provider Treatment Plan form will be ineligible for payment.

Durable Medical Goods/MRI and CAT Scans/Ambulatory Surgical Center

For non-emergency benefits, the following goods and services may be secured through State Farm or its designated vendors:

- Durable Medical Goods with an aggregate cost or monthly rental in excess of $75, including durable medical equipment and associated supplies, prosthetics and orthotics
- Magnetic Resonance Imagery (MRI)
- Computer Assisted Tomography (CAT)

The availability of vendors for durable medical goods, MRI's, and CAT Scans does not waive the requirement for Decision Point review and Pre-certification of these goods or services.

A 30% penalty shall apply if the above noted goods or services are not procured through our designated vendor's network. This penalty is in addition to any other policy or statutory deductible, co-payment and penalty application under this Plan and State Farm Auto policy.

Durable Medical Goods: State Farm's designated vendor for durable medical goods is Pro-Fit L.L.C. The system of medical goods acquisition will be a delivery system to the injured person's location.

When prosthetic or orthotic products are prescribed and evaluated as medically necessary through the Decision Point Review/Pre-certification process, Pro-Fit L.L.C. will contact the injured person to schedule an appointment to fit such equipment within three (3) business days of receipt of notice.

If durable medical goods are not prescribed or evaluated as medically necessary through the Decision Point Review/Precertification process, the injured party may contact State Farm directly.

MRI/CAT Scan Imaging Vendors: CSG will utilize Raytel Imaging Network, and Atlantic Imaging Group (AIG) and Tilton Dynamic Imaging to offer fully licensed facilities statewide, for MRI and CAT scan testing.

The patient and provider will receive a Decision Point Review/Pre-certification Evaluation letter advising if the request to review or pre-certify MRI's or CAT Scans was evaluated as medically necessary. The Evaluation letter will also advise the patient of options available to receive in-network services, and an explanation of the 30% co-payment penalty that shall apply for failure to obtain these services from an in-network facility. Using the patient's home address, CSG will provide a list of network facilities in the patient's county of residence as well as the immediate surrounding counties. In addition, the patient/provider can access a toll free number for centralized scheduling at any of the facilities listed, or they can contact CSG directly to assist in the scheduling of their testing needs. All appointments will be scheduled within three (3) business days. For information regarding available network facilities for MRI's or CAT Scans, the injured party or his or her designee and the treating medical provider may contact State Farm, access CSG's website at www.csg-inc.net/statefarm.htm or call CSG at 1-877-258-2378.

Penalties

a) State Farm shall assess an additional co-payment penalty for not providing MSR information within 30 days of the loss. Penalties will be assessed as follows:
    1. For failure to provide information timely, penalties shall reduce the amount of reimbursement for medically necessary expenses incurred more than 30 days after the accident and until notification is received. The additional co-payment shall be:
        i. 25% when received more than 30 days after the accident; or ii. 50% until notification is received if 60 or more days after the accident;
b) State Farm shall assess an additional co-payment penalty for medically necessary diagnostic tests, treatments, durable medical goods incurred without first complying with the provisions of the Plan. The treating provider's noncompliance with the provisions of the Plan shall trigger this additional co-payment penalty. No penalty under this provision shall be applied within the first 10 days after the accident or treatment administered during emergency care.

    Non-compliance, which shall result in the imposition of a 50% co-payment penalty, includes any of the following:
    1. Failure to follow the Pre certification requirements of the Plan.
    2. Failure to follow the Decision Point Review requirements of the Plan.
    3. Failure to provide clinically supported findings that support the treatment, diagnostic tests, or durable medical equipment at the time of the request for Decision Point Review/Pre-certification.

    Non-compliance, which shall result in the imposition of a 30% co-payment penalty, includes any of the following:
    1. Failure to secure durable medical goods from State Farm or its designated vendor(s).
    2. Failure to secure specified diagnostic imaging/testing from State Farm or its designated vendor(s).

Assignments: As a condition of the assignment of benefits, the treating medical provider or provider of service benefits agrees to the following:

1) **Comply with all the requirements of the Plan**
2) **Initiate all Pre-certification and Decision Point Review requests as required by the Plan.**
3) **In the event that the provider fails to comply with the conditions of the Plan, and such failure results in the imposition of a co-payment penalty, the provider will hold the patient harmless for such co-payment penalty insofar as the provider will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty.**
4) **Submit disputes as defined in the Plan to the Internal Appeals Process set forth therein. After final determination, submission of disputes not resolved by the Internal Appeals process to the Personal Injury Protection Dispute Resolution process set forth in N.J.A.C. 11:3-5.**
5) **Submit all disputes not subject to the Internal Appeals process to the Personal Injury Protection Dispute Resolution process set forth in N.J.A.C. 11:3-5.**
6) **Submit medical records with clinically supported findings to support the diagnosis, causal relationship to the accident and care plan.**
7) **Comply with a request to (i.) submit to an examination under oath, and (ii.) provide the Company with any other pertinent information/documentation that it requests.**
8) **Agree not to pursue payment directly from the patient, with the exception of deductibles and co-payments. I (We) may revoke the assignment, and I (we) shall be entitled to pursue payment from the patient, when benefits are not payable due to lack of coverage and/or violation of a policy condition by the patient.**

State Farm's Assignment of Benefits is the only valid assignment of benefits. State Farm has the right to reject, terminate or revoke the Assignment of Benefits. An assignment of benefits may require State Farm's written consent.

For a copy of the applicable Assignment of Benefits, it is available at State Farm's website.

State Farm Indemnity Company State Farm Guaranty Insurance Company

Personal Injury Protection Benefits **Conditional**

Assignment of Benefits

(For Accidents Occurring on and after 11/1/2011)

Policy Number: Policy_Number Claim Number: Claim_RefNumber

Patient's Name: Injured_FullName

I authorize and request State Farm Indemnity Company/State Farm Guaranty Insurance Company ("State Farm") to pay directly to the above-named medical provider, the amount due to me under the terms of the above-referenced policy as a result of medical care rendered by that medical provider and all medical staff associated with the provider's office.

_____ Date: _____

Patient's Signature or Parent/Legal Guardian

I have read the information contained in the State Farm informational letter concerning the Decision Point Review Plan, including Medical Services Review, Decision Point Review and precertification requirements (collectively the "Plan") and, as a condition precedent to State Farm's acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office, to the following:

1) I (We) will comply with all the procedures of the Plan.
2) I (We) will initiate all Pre-certification and Decision Point Review requests as required by the Plan.
3) In the event that I (we) fail to comply with the conditions of the Plan, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty.
4) I (We) will submit disputes as defined in the Plan to the Internal Appeals Process set forth therein. After final determination, submission of disputes not resolved by the Internal Appeals process to the Personal Injury Protection Dispute Resolution process set forth in N.J.A.C. 11:3-5.
5) I (We) will submit all disputes not subject to the Internal Appeals process to the Personal Injury Protection Dispute Resolution process set forth in N.J.A.C. 11:3-5.
6) I (We) will submit medical records with clinically supported findings to support the diagnosis, causal relationship to the accident and care plan.
7) I (We) will comply with a request to (i.) submit to an examination under oath, and (ii.) provide the Company with any other pertinent information/documentation that it requests.
8) I (We) agree not to pursue payment directly from the patient, with the exception of deductibles and co-payments. I (We) may revoke the assignment, and I (we) shall be entitled to pursue payment from the patient, when benefits are not payable due to lack of coverage and/or violation of a policy condition by the patient.

I (we) agree that State Farm's Assignment of Benefits is the only valid assignment of benefits. I (we) agree that State Farm has the right to reject, terminate or revoke this assignment of benefits. I (we) agree that this assignment of benefits may require State Farm's written consent.

_____ Date: _____

Provider's Signature

_____ TIN: _____

Provider's Name (Please Print)

Address: _____

_____

_____