Insurer Name
Address
City, State, Zip
Phone Fax

Date (##/##/####)

Physician Name
Street Address
City, State, Zip

Claimant:
Claim Number:
Medlogix ID #:
Date of Accident:
Insured:

Dear Provider:

This letter is to advise you that Medlogix is handling decision point review/precertification, medical service review and medical fee schedule calculations of this claim for Allstate New Jersey Insurance Company and Allstate New Jersey Property and Casualty Insurance Company's (ANJIC/ANJP&C), your patient's no-fault insurance carrier. Pursuant to N.J.A.C. 11:3-4, you are required to notify us of those services you intend to perform on the Eligible Insured, as hereinafter explained. ANJIC/ANJP&C has contracted with Medlogix (the "PIP Vendor") for these purposes.

In accordance with N.J.A.C. 11:3-4.7(c) 3, a copy of the informational materials for policy holders, injured persons and providers approved by the New Jersey Department of Banking and Insurance, is available through our website @ allstate.com and Medlogix's website @ www.medlogix.com

Please note, no decision point or precertification requirements shall apply within 10 days of the insured event or to treatment administered in emergency care. This provision should not be construed so as to require reimbursement of tests and treatment that are not medically necessary.

CARE PATHS/DECISION POINT REVIEW

As mentioned above, pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance (the "Department") 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 that treatment be evaluated at certain intervals called **Decision Points**. At Decision Points, you must

provide us information about further treatment you intend to provide. This is called **Decision Point Review.** In addition, the administration of any test listed in N.J.A.C. 11:3-4.5(b) 1-10 also requires Decision Point Review, regardless of the diagnosis. If you fail to submit requests for Decision Point Reviews or fail to provide clinically supported findings that support the request, payment of your bills will result in a co-payment of 50% (in addition to any deductible or co-payment that applies under the policy) of the eligible charge for medically necessary services. The **Care Paths** and accompanying rules are available on the Internet at the Department's website at www.nj.gov/dobi/aicrapg.htm or can be obtained by contacting Medlogix @ 1 (877) 258-CERT (2378).

MANDATORY PRECERTIFICATION

For treatment, diagnostic testing or durable medical equipment not included in the care paths or subject to Decision Point Review, you are required to obtain precertification of all the services listed below. If you fail to submit requests for the precertification of all the services listed below or fail to provide clinically supported findings that support the request, payment of your bills will result in a co-payment of 50% (in addition to any deductible or co-payment that applies under the policy) of the eligible charge for medically necessary services. You are encouraged to maintain communication with Medlogix on a regular basis as precertification requirements may change. Precertification is mandatory as to any of the following medical services once 10 days have elapsed since the accident:

1. Non-Emergency Inpatient and Outpatient Care including the facility where the services will be rendered and any provider services associated with these services and/or care.
2. Non-emergency surgical procedures, performed in a hospital, freestanding surgical center, office, etc., and any provider services associated with the surgical procedure.
3. Non-Emergency inpatient and outpatient Psychological/Psychiatric Services
4. Outpatient care including follow up evaluations for soft tissue/disc injuries of the injured party's neck, back and related structures not included within the diagnoses covered by the Care Path
5. Pain cream and/or compound creams
6. Extended Care and Rehabilitation Facilities
7. All Home Health Care
8. Computerized muscle testing
9. Cat Scan w/Myelogram
10. PENs/PNT
11. Skilled Nursing / Rehabilitation Services
12. Trigger Point Dry Needling
13. Compound Drugs
14. Drug Screening
15. Schedule II, III and IV Controlled Substances, as defined by the Drug Enforcement Administration (DEA), when prescribed for more than three months;
16. Discogram
17. Infusion Therapy
18. Current perceptual testing;

19. Temperature gradient studies;
20. Work hardening;
21. Carpal Tunnel Syndrome;
22. Vax-D / DRX types devices ;
23. Podiatry;
24. Audiology;
25. Bone Scans.
26. Non-Emergency Dental Restoration
27. Prescriptions costing more than $50.00;
28. Treatment, testing and/or durable medical goods of Temporomandibular disorders and/or any oral facial syndrome
29. Transportation Services costing more than $50.00;
30. Any procedure that uses an unspecified CPT; CDT; DSM IV; HCPCS codes.
31. Durable Medical Goods, including orthotics and prosthetics that collectively exceed $50.00 cost and/or monthly rental greater than 30 days.
32. Non-medical products, devices, services and activities and associated supplies not exclusively used for medical purposes or as durable medical goods, with a cost of $50.00 and/or monthly rental greater than 30 days, including but not limited to:
    a. vehicles
    b. modification to vehicles
    c. durable goods
    d. furnishings
    e. improvements or modifications to real or personal property
    f. fixtures
    g. recreational activities and trips
    h. leisure activities and trips
    i. spa/gym membership
33. Physical, Occupational, Speech, Cognitive, or other restorative therapy or Body part manipulation, including massage therapy, except that provided for Identified Injuries in accordance with Decision Point Review.
34. All Pain Management services, except as provided for Identified Injuries in accordance with Decision Point Review, including but not limited to:
    a. acupuncture
    b. nerve blocks
    c. manipulation under anesthesia
    d. anesthesia when performed in conjunction with invasive techniques
    e. radio frequency/rhyzotomy
    f. narcotics, when prescribed for more than 3 months
    g. biofeedback
    h. implantation of spinal stimulators or spinal pumps
    i. trigger point injections
    j. tens units (transcutaneous electrical nerve stimulation)
    k. PENs/PNT

VOLUNTARY PRECERTIFICATION

You are encouraged to participate in a Voluntary Precertification process by providing a comprehensive treatment plan for both identified and other injuries to Medlogix. An approved treatment plan means that as long as treatment is consistent with the approved plan, additional notification to Medlogix at Decision Points and for Treatment, Diagnostic Testing or Durable Medical Equipment requiring precertification is not required.

HOW TO SUBMIT DECISION POINT REVIEW/PRECERTIFICATION REQUESTS

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

In order for Medlogix to complete the review, you are required to submit all requests on the "Attending Physicians Treatment Plan" (APTP) form. A copy of this form can be found on the DOBI web site www.nj.gov/dobi/aicrapg.htm, Medlogix's web site www.medlogix.com or by contacting Medlogix @ (877) 258-CERT (2378).

Please return this completed form, along with a copy of your most recent/appropriate progress notes and the results of any tests relative to the requested services to Medlogix via fax at (856) 910-2501 or mail to the following address: Medlogix, 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619, ATTN.: Precertification Department. Its phone number is (877) 258-CERT (2378).

PROPERLY SUBMITTED REQUESTS

A properly submitted APTP form must be completed in its entirety. It must include the Eligible Insured's full name and birth date, the claim number, the date of the accident, diagnoses / ICD-9 code(s) or ICD-10 code(s), each CPT code requested including frequency, duration and signature of the requesting healthcare provider.

Properly submitted requests for decision point review and precertification must also include legible clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested. Clinically supported findings, supplied to Medlogix, must not only be legible but also establish that a health care provider, prior to selecting, performing or ordering the administration of a treatment, diagnostic testing or durable medical equipment, has:

Personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment, diagnostic testing or durable medical equipment;

1) Physically examined the patient, including making an assessment of any current and/or historical subjective complaints, observations, objective findings, neurologic indications and physical tests;
2) Considered the results of any and all previously performed tests that relate to the injury and which are relevant to the proposed treatment, diagnostic testing or durable medical equipment;

and
3) Recorded and documented these observations, positive and negative findings and conclusions on the patient's medical records.

Providers who submit Decision Point Review/Precertification are those providers who, in part, physically and personally perform evaluations of the Eligible Insured's condition, state the specific treatment and set treatment goals. Allstate New Jersey/Allstate Property & Casualty or Medlogix will not accept Decision Point Review/Precertification requests from the following providers;

1) Hospitals
2) Radiologic Facilities
3) Durable Medical Equipment Companies
4) Ambulatory Surgery Centers
5) Registered bio-analytical laboratories
6) Licensed health maintenance organizations
7) Transportation Companies
8) Suppliers of prescription drugs/pharmacies

If any of the above-restricted providers submit a Decision Point Review/Precertification request, Medlogix will respond to that submitting provider no later than three business days after the request informing them that they are a restricted provider and instruct them that the submission must be made by the referring/treating provider.

Within three business days following receipt of a properly submitted request, Medlogix, will provide its determination. Our failure to respond within three business days will allow a provider to continue treatment until we provide the required notice.

When an improperly submitted request is received, Medlogix, will inform you what additional medical documentation or information is required. An administrative denial for failure to provide required medical documentation or information will be issued and will remain in effect until all requested information needed to properly process a review to determine medical necessity regarding the requested treatment/testing and/or durable medical equipment is received. Our determination will be provided within three business days following receipt of the additional required documentation or information. If we fail to notify the Eligible Insured or provider of our determination within 3 business days following receipt of the additional required documentation or information, you may continue with the test or treatment until our final determination is communicated to you.

Any denial of treatment or testing based on medical necessity shall be made by a physician or dentist.

PLEASE NOTE: Authorized testing, treatment and/or durable medical equipment is only approved for the range of dates noted in the care plan evaluation letter(s). If you intend to perform authorized services beyond the approved range of dates, you must resubmit the request in accordance with the Properly Submitted Request section above.

Expired Authorization:
If you fail to follow the decision point review/precertification procedures identified in this document, any approved testing, treatment and/or durable medical equipment completed after the authorization period (last date in the range of dates indicated in the care plan evaluation letter) expires will be subject to a penalty co-pay of 50%, even if the services are determined to be medically necessary.

To clarify the Medlogix processing time, 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 three (3) business days from the date Medlogix receives the submission. Medlogix 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, Medlogix's decision is due no later than close of business Monday, February 11, 2013.

INDEPENDENT MEDICAL EXAMS

If the need arises for Medlogix to utilize an independent medical exam during the decision point review/precertification 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 Eligible Insured or his or her designee, scheduling the exam within seven calendar days of the receipt of the attending physicians treatment plan form (unless the Eligible Insured agrees to extend the time period), having the exam conducted by a provider in the same discipline, scheduling the exam at a location reasonably convenient to the Eligible Insured, and providing notification of the decision within three business days after attendance of the exam.

Except for non-emergent tests, surgery, procedures performed in ambulatory surgical centers, and invasive dental procedures, treatment may proceed while the examination is being scheduled and until the results become available. However only medically necessary treatment related to the motor vehicle accident will be reimbursed. If the examining provider prepares a written report concerning the examination, the Eligible Insured, or his or her designee, shall be entitled to a copy of the report upon request.

The Eligible Insured is required to present photo identification, or any form of identification, to the

examining provider at the time of the exam. Failure to comply with this requirement will result in an unexcused failure to attend the examination.

If the Eligible Insured needs to reschedule the appointment, they must contact Medlogix at (877) 258-CERT (2378) no less than three (3) business days prior to the scheduled appointment. Failure to comply with this requirement will result in an unexcused failure to attend the examination.

The Eligible Insured must provide all diagnostic test results including studies before or at the time of the examination. Failure to provide the required medical records and/or diagnostic studies/tests will be considered an unexcused failure to attend the IME. If the Eligible Insured has 2 or more unexcused failures to attend the scheduled exam notification will be immediately sent (on a Care Plan Evaluation Letter) to the Eligible Insured, or to his or her designee, and all providers treating the Eligible Insured for the diagnosis (and related diagnosis) contained in the Attending Provider Treatment Plan form. The notification will place the Eligible Insured on notice that all further 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.

An example of the Eligible Insured's unexcused failures to attend the exam may include but are not limited to one of the following:

1) Failure to provide the medical records and/or diagnostic films before or on the day of examination;
2) To reschedule the examination, it must be done with 3 or more business days' notice;
3) Failure to present valid photo identification or any form of identification at the time of the examination;
4) Failure to attend a scheduled examination of additional treatment/test or services in question.

VOLUNTARY UTILIZATION PROGRAM

Medlogix, has a provider network that is available to Eligible Insured. As outlined in N.J.A.C. 11:3-4.8, the Medlogix Network is an approved network as part of a workers' compensation managed care organization pursuant to N.J.A.C. 11:6. The benefits of the network include ease of access, credentialed and quality providers and the fact that the Eligible Insured penalty copayment is waived when accessing a network provider.

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

1) Magnetic Resonance Imaging (MRI)
2) Computer Assisted Tomography (CT/CAT Scans)
3) Needle Electromyography (needle EMG), H-reflex and nerve conduction velocity (NCV) tests *

4) Somatosensory Evoked Potential (SSEP)
5) Visual Evoked Potential (VEP)
6) Brain Audio Evoked Potential (BAEP)
7) Brain Evoked Potential (BEP)
8) Nerve Conduction Velocity (NCV)
9) H reflex Study
10) Electroencephalogram (EEG)
11) Durable Medical Equipment with a cost or monthly rental in excess of $50.
12) Prescription Drugs
13) Services, equipment or accommodations provided by an ambulatory surgery facility.

* except when performed together by the treating physician.

When any of the services listed above is authorized at any point in the **decision point review** or **precertification** or appeal process, information about accessing our voluntary network of providers is available on the websites or at the toll-free numbers listed below. Those individuals who choose not to utilize the network will be assessed a penalty copayment not to exceed 30% of the eligible charge, including if the treatment is denied but subsequently approved. That penalty copayment will be the responsibility of the eligible injured party.

There are two specific Networks for the below specified services:

1) Prescription Drugs:
    i) Optum at 1-800-964-2531 or at www.tmesys.com
2) Diagnostic Imaging/Electrodiagnostic Testing:
    i) Information regarding the Medlogix, provider network is available to you at https://www.chn.com/Provider/Search or by calling (877) 258-CERT (2378)
3) Durable Medical Equipment:
    i) Information regarding the Medlogix, provider network is available to you at https://www.chn.com/Provider/Search or by calling (877) 258-CERT (2378)
4) Services, equipment or accommodations provided by an ambulatory surgery facility.
    i) Information regarding the Medlogix, provider network is available to you at https://www.chn.com/Provider/Search or by calling (877) 258-CERT (2378)

Information regarding our provider network is available to you at www.medlogix.com or by calling (877) 258-CERT (2378). Our provider network includes Medlogix providers as well as the CHN Network

PREFERRED PROVIDER ORGANIZATION (PPO)

In addition, Medlogix, makes available a Preferred Provider Organization (PPO) that includes all specialties, hospitals, outpatient and urgent care facilities. The use of a provider from our PPO is strictly voluntary and is provided as a service to you. A penalty copayment will not be applied if you choose to select a provider outside this preferred provider network. Preferred providers have

facilities located throughout the state. Information regarding our PPO network is available to you at www.medlogix.com or by calling (877) 258-CERT (2378). Our PPO Network includes Medlogix, providers as well as the CHN Network.

PENALTY

As outlined in N.J.A.C. 11:3-4.4 (d), failure to request Decision Point Review or Precertification as required in our Decision Point Review / Precertification plan will result in a 50% penalty copayment. This co-payment penalty will be in addition to any co-payment stated in the schedule of your policy. Failure to submit clinically supported findings that support your decision point review or precertification request will result in a 50% copayment penalty. Failure to use an approved network provider for Prescription Drugs, Diagnostic Imaging/Electro diagnostic Testing, Durable Medical Equipment, and services, equipment or accommodations provided by an ambulatory surgery facility will result in a 30% penalty copayment. All penalty copayments will be applied before the application of the policy copayment and deductible.

INTERNAL APPEAL 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.

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 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.

General Terms: As a condition precedent to filing an arbitration or litigation, a provider of service benefits who has accepted an assignment must submit a written request to appeal any and all disputes, including but not limited to any claims for unpaid medical bills for medical expenses and for unpaid services not authorized and/or denied in the decision point review and precertification process. The request must specify the issue(s) contested and provide supporting documentation. Any medical provider that has accepted an assignment of benefits must comply with the Internal Appeals Process prior to initiating arbitration or litigation. Pursuant to N.J.A.C. 11:3-5.1, any completed appeal may be submitted to Alternate Dispute Resolution. If the Eligible Insured or health care provider retains counsel to represent them during the appeal process, they do so strictly at their own expense. No counsel fees or costs incurred during the appeal process shall be compensable. To the extent permitted by law, the results of said Alternate Dispute Resolution processes shall be final and binding.
All appeals must include the appeal form established by the Department by order in accordance with N.J.A.C. 11:3-4.7B(c), along with all supporting documentation. Any submission received from a medical provider without the appeal forms required by N.J.A.C. 11:3-4.7B(c) and/or

supporting documentation shall not be considered as an appeal.

The pre and post service appeal forms must be completed including, but not limited to the minimum required fields as indicated by asterisk (*). Further, an appeal rationale narrative is required to be included within these forms. Failure to comply with these requirements will result in an administrative denial of the appeal.
Any appeal not sent via the aforementioned fax, email or web address must be submitted via certified mail/return receipt requested or via courier that provides proof of delivery to Medlogix. Proof of receipt by the insurer must be provided by the disputing party at the insurer's request.

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

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.

Pre-service Appeals:

The Pre-service appeal form and any supporting documentation shall be submitted by the provider to Medlogix via fax @ (856) 910-2501 or in writing @ 300 American Metro Blvd., Suite 170, Hamilton, NJ 08619.

If a healthcare provider disagrees with a determination related to decision point review and/or precertification of any medical procedure, treatment, diagnostic test, other service or dispensing of any durable medical equipment, prescription or other items, that healthcare provider shall submit a pre-service appeal for reconsideration of that decision in accordance with the guidelines set forth in N.J.A.C. 11:3-4.7B.

All pre-service appeals shall be submitted no later than 30 calendar days from the medical provider's receipt of the adverse determination and shall include the basis for the appeal along with the medical criteria to support the dispute of that medical determination. Failure to comply with these requirements will result in an administrative denial of the appeal.

Submission of information identical to the initial material submitted in support of the request shall not be accepted as a request for appeal. The Eligible Insured, and/or health care providers, may be requested to submit additional documentation in order to complete the internal review. If so, the deadline for the pre-service appeal response will toll until such requested documentation is received by Medlogix.

A Medlogix Medical Director will be available to consult with the health care provider during the pre-service appeal process. If it is determined that peer review or an Independent Medical

Examination is appropriate, this information will be communicated within 14 calendar days of receipt of the pre-service appeal. A final decision for pre-service appeals will be communicated the injured party and health care provider within 14 calendar days of receipt of the pre-service appeal form and 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 calendar days will be added to the response time requirement.

Consistent with the terms of the decision point review plan and the assignment of benefits provision, a provider who proceeds under an assignment of benefits must utilize the pre-service appeal process which shall be a condition precedent to filing of a demand for arbitration for any issue related to medical necessity.

Post-service Appeals:

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

If a health care provider disagrees with a determination related to the payment of any medical procedure, treatment, diagnostic test, other service or dispensing of any durable medical equipment, prescription or other items, that healthcare provider shall submit a post-service appeal for reconsideration of that decision in accordance with the guidelines set forth in N.J.A.C. 11:3-4.7B.

All post-service appeals shall be submitted at least 45 calendar days prior to initiating dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in the Superior Court. Post-service appeals shall include all new supporting documents necessary to evaluate and reconsider payment. Failure to comply with this requirement will result in an administrative denial of the appeal. The Eligible Insured, and/or health care providers, may be requested to submit additional documentation in order to complete the internal review. If so, the deadline for the post-service appeal response will toll until such requested documentation is received by Medlogix. All post-service appeals involving UCR disputes, must be accompanied by UCR proofs from the requesting health care provider. All post-service appeals involving PPO disputes, must be accompanied by any information which the health care provider intends to prove or rebut the application of the subject PPO agreement and/or rates. All post-service appeals involving Health Insurance Carrier/PIP Secondary disputes, must be accompanied by Health Insurance carrier EOBs/ proofs from the requesting health care provider.

A final decision for post-service appeals will be communicated to the Eligible Insured and health care provider within 30 calendar days of receipt of the post-service appeal form and 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 calendar days will be added to the response time requirement.

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.

Consistent with the terms of the decision point review plan and the assignment of benefits provision, a provider who proceeds under an assignment of benefits must utilize the post-service appeal process which shall be a condition precedent to filing of a demand for arbitration for any issue related to bill payment.

Should any action be filed seeking relief under the New Jersey Insurance Fraud Prevention Act, N.J.S.A. 17:33A-1, et seq., N.J.S.A. 39:6A-13(g) or any cause of action alleging fraud or misconduct, the insured and/or the provider must agree to put any arbitration proceedings in abeyance until the legal action is resolved.

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Should you have any questions or require any further information not available through the websites, don't hesitate to contact us or Medlogix.

Sincerely,

Insurer Name
Address
City, State, Zip