

HARTFORD FIRE INSURANCE COMPANY
AUTO INSURANCE PIP DECISION POINT REVIEW PLAN
FILING WITH
NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE

Updated April 4, 2017

Introduction

The Hartford Fire Insurance Company and its affiliates licensed to write auto insurance in the state of New Jersey, including Hartford Accident & Indemnity Company, Hartford Casualty Insurance Company, Hartford Insurance Co of the Midwest, Hartford Underwriters Insurance Company, Sentinel Insurance Company, Ltd., Trumbull Insurance Company, Twin City Fire Insurance Company (hereafter collectively “The Hartford”) are submitting this update to its currently approved Decision Point Review Plan (“Plan”) on file with the New Jersey Department of Banking and Insurance (“DOBI”) in conformance with Rule 11:3-4 of the New Jersey Administrative Code (hereinafter “Rule 11:3-4”). The Plan was originally approved on April 3, 2000. A prior amendment was submitted in compliance with requirements set forth in revisions to Rule 11:3-4 which were effective October 27, 2004, and with bulletin 04-19 issued by the DOBI. This amendment is being submitted in compliance with requirements set forth in NJAC Rule 11:3-4.7B which will become operative April 17, 2017.

A clean version of this amended filing is provided herein, and a comparison version to the earlier filing is also separately provided.

A) Scope of Program Services

This Hartford Decision Point Review Program (“Program”) will provide the following services:

- 1) Medical necessity review of treatment of identified injuries at the decision points defined in the Treatment of Accidental Injury to the Spine and Back Care Paths (“Care Paths”) delineated in the Appendix to Rule 11:3-4;
- 2) Medical necessity review and approval of the administration of the diagnostic tests defined in Section 5(b) of Rule 11:3-4.

This Program will fulfill insurer obligations for decision point review services that are mandated under Section 7 of Rule 11:3-4.

B) Limitations on Scope of Program

The review activities described herein do not apply to services occurring within 10 days of the insured event in accordance with Section 11:3-4.7(e) or to emergency care services in accordance with Sections 11:3-4.2 and 11:3-4.5(e).

C) Applicable Claims

The Hartford will conduct the Decision Point Review Program described in this Plan for medical claims arising from automobile insurance policies containing personal injury protection coverage, and from motor bus insurance policies containing medical expense benefits coverage.

D) Program Resources

The Hartford will utilize its internal utilization review program to provide medical decision point review services in New Jersey as required under Rule 11:3-4. The Hartford utilization review program is staffed by staff nurse reviewers from The Hartford's Property and Casualty Claim Medical Management Group.

The Hartford's utilization review programs are accredited by the American Accreditation HealthCare Commission/URAC organization and operate throughout the country for Hartford's property and casualty insurance customers. Though not required under Rule 11:3-4, URAC compliance reflects The Hartford's commitment to industry-standard utilization review services. Hartford staff conducting decision point review will coordinate with Hartford claim administration staff for claimants whose medical services are subject to decision point review.

The Hartford also utilizes physician review services in the DPR Program through its contract with the First Managed Care Options ("First MCO") organization. These physician reviewers include peer reviewers, independent medical examiners and the First MCO medical director.

The Hartford's NJ DPR program's applicable close of business is 4:30 p.m. Eastern Standard Time.

The Hartford provides a network of providers, using the Procura Management Inc (a Healthcare Solutions Company) Network.

E) Decision Point Review Program Description

Disclosure of Plan Requirements to Policyholders and to Medical Providers

The Hartford will inform the policyholder/claimant and the treating provider about the requirements of the Decision Point Review Program in conformance with Section 11:3-4.7(d). To inform the policyholder/ claimant, The Hartford will include information describing the Program in:

- the cover letter provided with new and/or renewal policies, and
- An attachment to the PIP-1 Application for Benefits-Personal Injury Protection Form which is sent following filing of the accident claim.

These informational materials describe how decision point review will be conducted and for which services, and clearly state that decision point review is not required for tests/treatments occurring within the first ten days of the accident or for emergency care services. Samples of this informational material are attached under Exhibit A.

The Hartford will inform the treating physician or other treating provider about the requirements of the Program in an attachment to the PIP-3 Attending Physician's Report Form which is sent following identification of the treating provider. The Attending Provider Treatment Plan Form will also be sent to the provider on which will be specified any medical information needed for the claim. The attachment describes how and when the provider should contact The Hartford to in order to procure approval for tests and/or treatment which are mandated for decision point review under Rule 11:3-4, and clearly states the exclusions for tests/treatments occurring within the first ten days of the accident and for emergency care services. The attachment delineates the minimum

information which the provider must include as clinically supported findings in order to justify authorization of the medical necessity of the test/treatment. Finally, the attachment states that The Hartford will respond to authorization requests within three business days of receipt of the information necessary to conduct the review, and that the provider is free to proceed with the test/treatment if he/she has not received a response from the Hartford within three business days after submission of the authorization request. Samples of the informational material which will be sent to the medical provider are attached under Exhibit B.

Medical Necessity Determination Procedures

The Hartford has established procedures for conducting decision point review on those medical treatments and tests which require review under Rule 11:3-4, which procedures are described in detail in Exhibit C. Upon receipt of proper notice and the necessary supporting information from the treating provider(s), The Hartford will conduct its review within three business days, and communicate its authorization or denial determination to the provider(s) and injured person. If The Hartford has not responded to a service authorization request within three business days, the requesting provider is free to proceed with the test/treatment.

The Hartford's DPR Program includes procedures for referral of cases to physician reviewers. These referral procedures are described in detail in Exhibit C. Any denial of reimbursement for further treatment or tests will be made by a physician reviewer. The Program includes procedures for referral of injured persons for physical examination where the notice and supporting materials are not sufficient to authorize or deny reimbursement of further treatment or tests in conformance with 11:3-4.7 (b)(2). The Hartford will notify the injured person or his or her designee that a physical examination is required before reimbursement of further treatment or tests can be authorized. The examination will be conducted by a provider in the same discipline as the treating provider at a location reasonably convenient to the injured person, and shall be scheduled within seven calendar days of receipt of notice unless the injured person agrees to extend the time period. The treating provider shall, upon the request of The Hartford, provide medical records and other pertinent information to the provider conducting the medical examination. The requested records shall be provided at the time of the examination or before. The Hartford shall notify the claimant and treating provider whether reimbursement for further treatment or tests is authorized as promptly as possible but in no case later than three days after the examination. If the examining provider prepares a written report concerning the examination, the claimant or his or her designee shall be entitled to a copy upon request. The Hartford will make its best efforts to ensure that its review activities conducted under this Program do not create undue interruption in the course of medical treatment.

F) Internal Appeals Procedure

The Hartford's process allows a treating provider who receives a denial or modification of authorization to submit an internal appeal of the decision.

There are two types of internal appeals:

1) Pre-Service Appeals

A pre-service appeal is an appeal of a decision point review and/or pre-certification 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").

- A New Jersey Pre-Service Appeal Form must be submitted no later than 30 calendar days after receipt of a written denial or modification of requested services.
- The New Jersey Pre-Service Appeal Form must be properly completed and submitted with any supporting medical information that justifies the medical necessity, or appropriateness of the service(s).

- The Hartford will provide a written response to the provider who submitted the pre-service appeal no later than 14 calendar days after receipt of the appeal form and any supporting medical information.

2) Post-Service Appeals

A post-service appeal is an appeal **subsequent to** the performance or issuance of services.

- A New Jersey Post-Service Appeal Form must be properly completed and submitted at least 45 calendar days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in Superior Court.
- The New Jersey Post-Service Appeal Form must be submitted with any supporting medical information that justifies the medical necessity, or appropriateness of the service(s).
- The Hartford will provide a written response to the provider who submitted the post-service appeal no later than 30 calendar days after receipt of the appeal form and any supporting medical information.

The New Jersey Pre-Service and Post-Service Appeals Forms (which are available on the New Jersey Department's website) should be submitted to The Hartford via facsimile at 866.771.6001 (same fax# to initiate a Decision Point Review with The Hartford). The Hartford will not accept any pre-service or post-service appeals that are submitted outside the required timeframes, without the required supporting documentation or without the forms established by the Department by Order in accordance with N.J.A.C. 11:3-4.7(d).

If you wish to appeal this matter further, you may do so in accordance with applicable law. You may contact your Hartford claim handler for assistance.

Appeal to PIP Coverage Dispute Resolution Panel

Parties affected by medical necessity determinations made pursuant to this Plan and Rule 11-3-4 may exercise any appeal rights permitted under applicable state law and regulations, specifically including the PIP coverage dispute resolution procedures set forth in N.J.A.C. 11:3-5.

Providers are only required to file a one-level internal appeal, for each appealable issue. That is, each appealable issue shall only be required to receive one internal appeal review prior to 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 amount the insurer should reimburse the provider for that same service. However, providers cannot request alternate dispute resolution without first having utilized the internal appeals process.

Determination and Appeals Notices

The Hartford provides written communication of the results of its DPR initial and appeals determinations to medical providers using the standard letters, which are attached in Exhibit D.

G) Application of Additional Co-Payments for Non-Compliance

In conformance with N.J.A.C. 11:3-4.4(d), failure to request decision point review where required or failure to provide clinically supported findings that support the treatment, diagnostic test, or durable medical equipment requested shall result in an additional co-payment up to 50 percent of the eligible charge for medically necessary diagnostic tests, treatments, surgery, durable medical goods and non-medical expenses that were provided between the time notification to The

Hartford was required and the time that proper notification is made and The Hartford has an opportunity to respond in accordance with its approved decision point review plan. The Hartford will not impose the additional co-payment where it has received the required notice but failed to act in accordance with its approved decision point plan to authorize or deny reimbursement of further treatment or tests.

H) Assignment of Benefits

At The Hartford's option, medical expense benefits under the policy may be assigned to a health care provider who complies with the requirements of the decision point review Plan and agrees that any disputed issue involving treatment or services provided to the eligible injured person must be resolved through the dispute resolution process. Failure on the part of a provider to comply with all the decision point review requirements or the dispute resolution process will render any prior assignment of benefits under the policy null and void. If the provider accepts direct payment of benefits, the provider is required to hold harmless the insured and The Hartford for any reduction of payment for services caused by the provider's failure to comply with the requirements of our decision point review Plan or with the terms of the insured's policy.

I) Coordination with Other Hartford Auto Claims Administration Functions

The Program will be conducted in coordination with other Hartford auto insurance claims processing activities. The Hartford will continue to make medical claims payments in accordance with the state fee schedule and with other applicable state law and regulations.

EXHIBIT A.1

DPR LANGUAGE IN POLICYHOLDER COVER LETTER

The Hartford informs the policyholder about the Decision Point Review Program by including the language delineated below in the Personal Injury Protection section of the cover letter sent to auto policyholders for new and renewal policies:

Please carefully read the section of your **Personal Injury Protection (PIP)** endorsement which describes how medical expense claims are handled under your PIP coverage. New Jersey law includes detailed provisions for determining whether medical expenses for the diagnosis and treatment of injuries sustained from covered automobile accidents are medically necessary. The law's definition of medically necessary services incorporates professional treatment protocols and standards of good practice, and also includes state-mandated standards for the use of certain diagnosis tests and treatment of certain injuries. The law requires insurers to review the medical necessity of specific medical tests and treatments for certain injuries in accordance with an approved "Decision Point Review Plan" which has been filed with the state. The Plan also includes a process for your provider to file an "Internal Appeal" should they disagree with the outcome of a decision point review, a pre-certification denial or modification of treatment or a denial subsequent to treatment having taken place. The Hartford's Plan includes a voluntary network for specific diagnostic tests, prescription drugs, and durable medical equipment. Those individuals who choose not to utilize the network may be assessed a penalty co-payment not to exceed 30% of the eligible charge. Decision point review does not apply to emergency care or to care occurring within the first ten days of the accident.

EXHIBIT A.2

DPR ATTACHMENT TO NJ PIP-1 APPLICATION FOR BENEFITS FORM

The Hartford informs the policyholder/ claimant about the Decision Point Review Program by including the following attachment to the PIP-1 Application for Benefits-Personal Injury Protection Form which is sent following filing of the accident claim:

Dear Policyholder/Claimant

The New Jersey Automobile Insurance Cost Reduction Act of 1998 (AICRA) sets forth certain requirements about the way medical expense claims are handled under your Personal Injury Protection coverage. See the PIP endorsement in your coverage. The AICRA law includes detailed provisions for determining whether medical expenses for the diagnosis and treatment of injuries sustained from covered automobile accidents are medically necessary. The law's definition of medically necessary services incorporates professional treatment protocols and standards of good practice, and also includes state-mandated standards for the use of certain diagnostic tests and treatment of certain injuries. The AICRA law requires insurers to review the medical necessity of specific medical tests and treatments for certain injuries in conformance with an approved "Decision Point Review Plan" which has been filed with and approved by the state.

This notice outlines the requirements concerning personal injury protection claims under New Jersey state law (New Jersey Administrative Code 11:3-4) applicable to auto insurers, their policyholders and medical providers, and includes specific requirements which medical providers must follow in order to ensure payment for medically necessary treatments, diagnostic tests, and durable medical equipment for injuries sustained in an automobile accident.

Decision Point Review: Services Requiring Authorization

Pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance has published standard courses of treatment, called **Care Paths**, for injuries to the neck and back, collectively referred to as **Identified Injuries**. The **Care Paths** provide that treatment be evaluated at certain intervals called **Decision Points**. At decision points, your doctor must provide us with prior notice and clinically supported findings about further treatment and/or the use of durable medical equipment that is intended to be provided (called Decision Point Review). Such information includes reasonable prior notice and the appropriate clinically supported findings that the proposed treatment and/or durable medical equipment is medically necessary. We can provide your doctor a copy of these **Care Paths** upon your request if they do not already have one. The **Care Paths** and accompanying rules are available on the Internet on the Department's website at www.state.nj.us/dobi/pipinfo/attpip.htm or by calling The Hartford at 800.280.0555.

In addition, N.J.A.C. 11:3-4.5 provides that certain diagnostic tests are subject to Decision Point Review, regardless of the diagnosis. If your doctor considers any of the following diagnostic tests to be medically necessary, he/she is required to notify us by providing written support and clinically supported findings to obtain our authorization prior to the administration of any of these tests.

- Needle electromyography (needle EMG)
- Somasensory evoked potential, visual evoked potential, brain audio evoked potential, brain evoked potential, nerve condition velocity, and H-reflex study
- Electroencephalogram (EEG)
- Videofluoroscopy
- Magnetic resonance imaging
- Computer assisted tomographic studies (CT, scan)
- Dynatron/cyber station/cybex

- Sonograms/ultrasound
- Thermography/thermograms
- Brain mapping

Please note that Decision Point Review requirements do not apply within ten (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.

Decision Point Review Procedure

Your doctor should initiate the medical review process by contacting The Hartford's decision point review organization via facsimile at 866.771.6001. Following receipt of the authorization request for further treatment, testing or durable medical equipment and clinically supported findings, The Hartford will review the request. Clinically supported findings are required to justify the medical necessity of the proposed test or treatment for this patient including the following minimum necessary information: date of accident, date(s) of previous treatment, clinical symptoms, diagnosis(es), pre-existing conditions, diagnostic tests performed and their results, recommended tests and/or treatments---along with any additional information necessary to justify the test/treatment.

Within three (3) business days of receipt of the authorization request, The Hartford will either 1) authorize the request, 2) modify the request, 3) request additional information, 4) deny the request, or 5) request an Independent Medical /Consultative Exam. The decision will be communicated by fax or by phone, and confirmed in writing. In the event The Hartford must request additional information, a decision will be communicated within three (3) business days of receipt of the additional information. If we have not responded within three (3) business days of our receipt of your authorization request, your doctor may proceed with the treatment, test or use of durable medical equipment.

If The Hartford requests that you attend an independent medical / consultative examination, the examination will be scheduled within seven (7) calendar days of receipt of the Decision Point Review request, unless the claimant agrees to extend the time frame. The examination will take place at a location convenient to you and with a provider in the same specialty as the treating provider. Your medical records and/or test results may be required to be provided to the examining provider at or before the scheduled appointment. The results of the examination will be made available within three (3) business days of the exam. If the examining provider prepares a written report, this report is available upon request. Medical treatment can proceed while the exam is being scheduled and until results become available.

If you have two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to you or your designee, and all providers treating you for the diagnosis (and related diagnoses) contained in the Attending Physician's Treatment Plan form. The notification will place you on notice that all future treatment, diagnostic testing or durable medical equipment required for the diagnosis (and related diagnosis) contained in the Attending Physician's Treatment Plan form will not be reimbursable as a consequence for failure to comply with the plan.

Appeals

The Hartford's process allows a treating provider who receives a denial or modification of authorization to submit an internal appeal of the decision.

There are two types of internal appeals:

1) Pre-Service Appeals

A pre-service appeal is an appeal of a decision point review and/or pre-certification 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”).

- A New Jersey Pre-Service Appeal Form must be submitted no later than 30 calendar days after receipt of a written denial or modification of requested services.
- The New Jersey Pre-Service Appeal Form must be properly completed and submitted with any supporting medical information that justifies the medical necessity, or appropriateness of the service(s).
- The Hartford will provide a written response to the provider who submitted the pre-service appeal no later than 14 calendar days after receipt of the appeal form and any supporting medical information.

2) Post-Service Appeals

A post-service appeal is an appeal **subsequent to** the performance or issuance of services.

- A New Jersey Post-Service Appeal Form must be properly completed and submitted at least 45 calendar days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in Superior Court.
- The New Jersey Post-Service Appeal Form must be submitted with any supporting medical information that justifies the medical necessity, or appropriateness of the service(s).
- The Hartford will provide a written response to the provider who submitted the post-service appeal no later than 30 calendar days after receipt of the appeal form and any supporting medical information.

The New Jersey Pre-Service and Post-Service Appeals Forms (which are available on the New Jersey Department’s website) should be submitted to The Hartford via facsimile at 866-771-6001 (same fax# to initiate a Decision Point Review with The Hartford). The Hartford will not accept any pre-service or post-service appeals that are not submitted within the required timeframes, submitted without the required supporting documentation or without the forms established by the Department by Order in accordance with N.J.A.C. 11:3-4.7(d).

Providers are only required to file a one-level internal appeal, for each appealable issue. That is, each appealable issue shall only be required to receive one internal appeal review prior to 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 amount the insurer should reimburse the provider for that same service. However, providers cannot request alternate dispute resolution without first having utilized the internal appeals process.

If you wish to appeal this matter further, you may do so in accordance with applicable law. You may contact your Hartford claim handler for assistance.

VOLUNTARY NETWORK PROGRAM (VNP):

Procura has a provider network that is available to you. As outlined in N.J.A.C. 11:3-4.8, the Procura 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 your penalty co-payment is waived when accessing a network provider.

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

- Magnetic Resonance Imaging (MRI)

- Computer Assisted Tomography (CT/CAT Scans)
- Needle Electromyography (needle EMG), H-reflex and nerve conduction velocity (NCV) tests *
- Somatosensory Evoked Potential (SSEP)
- Visual Evoked Potential (VEP)
- Brain Audio Evoked Potential (BAEP)
- Brain Evoked Potential (BEP)
- Nerve Conduction Velocity
- H reflex Study
- Electroencephalogram (EEG)
- Durable Medical Equipment with a cost or monthly rental in excess of \$300.00
- Prescription Drugs
- 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 through the decision point review or precertification process, information about accessing our voluntary network of providers will be supplied to both the injured party and the requesting provider. Those individuals who choose not to utilize the network may be assessed a penalty co-payment not to exceed 30% of the eligible charge. That penalty co-payment will be the responsibility of the injured party.

Below is the contact information for the Network for the below specified approved services:

- A. Prescription Drugs:
Cypress Care at (800) 419-7191 or at www.cypresscare.com.
- B. Diagnostic Imaging/Electrodiagnostic Testing:
Information regarding the Procura provider network is available to you at www.procura-inc.com or you may call (866) 212-4014.
- C. Durable Medical Equipment:
Information regarding the Procura provider network is available to you at www.procura-inc.com or you may call (866) 212-4014.
- D. Services, equipment or accommodations provided by an ambulatory surgery facility.
Information regarding the Procura provider network is available to you at www.procura-inc.com or you may call (866) 212-4014.

Information regarding Procura's provider network is available to you at www.procura-inc.com or you may call (866) 212-4014. Our provider network includes Procura providers as well as the Magnacare Network.

Assignment of Benefits

At our option, medical expense benefits under the policy may be assigned to a health care provider who complies with the requirements of decision point review and agrees that any disputed issued involving treatment or services provided to the eligible injured person must be resolved through the dispute resolution process. Failure on the part of a provider to comply with all decision point review requirements or the dispute resolution process will render any prior assignment of benefits under the policy null and void. If the provider accepts direct payment of benefits, the provider is required to hold harmless the insured and us for any reduction of payment for services caused by the provider's failure to comply with the terms of the insured's policy.

Please feel free to call me at 800.280.0555 for assistance with these state requirements.

Sincerely,

<Hartford Claims Rep>

EXHIBIT B

DPR EXPLANATORY LETTER TO MEDICAL PROVIDER ATTACHMENT TO NJ ATTENDING PROVIDER TREATMENT PLAN FORM

<Physician Name>
<Address>

Re: <Claimant's Name; Identifiers; Date of Accident >

Dear Dr. < >:

This letter outlines the requirements concerning personal injury protection claims under New Jersey state law (New Jersey Administrative Code 11:3-4) applicable to auto insurers, their policyholders and medical providers, and includes specific requirements which medical providers must follow in order to ensure payment for medically necessary treatments, diagnostic tests, and durable medical equipment for injuries sustained in an automobile accident.

Decision Point Review: Services Requiring Authorization

Pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance has published standard courses of treatment, called **Care Paths**, for injuries to the neck and back, collectively referred to as **Identified Injuries**. The **Care Paths** provide that treatment be evaluated at certain intervals called **Decision Points**. At decision points, you must provide us with prior notice and clinically supported findings about further treatment and/or the use of durable medical equipment that is intended to be provided (called Decision Point Review). Such information includes reasonable prior notice and the appropriate clinically supported findings that the proposed treatment and/or durable medical equipment is medically necessary. We can provide you a copy of these **Care Paths** upon your request if you do not already have one. The **Care Paths** and accompanying rules are available on the Internet on the Department's website at <http://www.naic.org/nj/filings.htm> or by calling The Hartford at 800.280.0555.

In addition, N.J.A.C. 11:3-4.5 provides that certain diagnostic tests are subject to Decision Point Review, regardless of the diagnosis. If you consider any of the following diagnostic tests to be medically necessary, you are required to notify us by providing written support and clinically supported findings to obtain our authorization prior to the administration of any of these tests.

- Needle electromyography (needle EMG)
- Somatosensory evoked potential, visual evoked potential, brain audio evoked potential, brain evoked potential, nerve conduction velocity, and H-reflex study
- Electroencephalogram (EEG)
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- Computer assisted tomographic studies (CT, scan)
- Dynatron/cyber station/cybex
- Sonograms/ultrasound
- Thermography/thermograms
- Brain mapping

Please note that Decision Point Review requirements do not apply within ten (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.

Decision Point Review Procedure

All requests for Decision Point Review must be submitted using the uniform Attending Provider Treatment Request form attached. Additional copies of this form are available on the New Jersey Department of Banking and Insurance website at: <http://www.nj.gov/dobi/aicrapg.htm> . You should initiate the medical review process by contacting The Hartford's decision point review organization via facsimile at 866.771.6001. Following receipt of your authorization request for further treatment, testing or durable medical equipment and clinically supported findings, The Hartford will review your request. Clinically supported findings are required to justify the medical necessity of the proposed test or treatment for this patient including the following minimum necessary information: date of accident, date(s) of previous treatment, clinical symptoms, diagnosis(es), pre-existing conditions, diagnostic tests performed and their results, recommended tests and/or treatments---along with any additional information necessary to justify the test/treatment.

Within three (3) business days of receipt of your authorization request, The Hartford will either 1) authorize the request, 2) modify the request, 3) request additional information, 4) deny the request, or 5) request an Independent Medical/Consultative Exam. The decision will be communicated by fax or by phone, and confirmed in writing. In the event The Hartford must request additional information, a decision will be communicated within three (3) business days of receipt of the additional information. If we have not responded to you within three (3) business days of our receipt of your authorization request, you may proceed with the treatment, test or use of durable medical equipment.

If The Hartford requests the claimant attend an independent medical / consultative examination, the examination will be scheduled within seven (7) calendar days of receipt of the Decision Point Review request, unless the claimant agrees to extend the time frame. The examination will take place at a location convenient to the claimant and with a provider in the same specialty as the treating provider. The claimant's medical records and/or test results may be required to be provided to the examining provider at or before the scheduled appointment. The results of the examination will be made available within three (3) business days of the exam. If the examining provider prepares a written report, this report is available upon request. Medical treatment can proceed while the exam is being scheduled and until results become available.

If the claimant has two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to the claimant or his / her designee, and all providers treating the claimant for the diagnosis (and related diagnosis) contained in the Attending Physician's Treatment Plan form. The notification will place the claimant on notice that all future treatment, diagnostic testing or durable medical equipment required for the diagnosis (and related diagnosis) contained in the Attending Physician's Treatment Plan form will not be reimbursable as a consequence for failure to comply with the plan.

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- A New Jersey Pre-Service Appeal Form must be submitted no later than 30 calendar days after receipt of a written denial or modification of requested services.

- The New Jersey Pre-Service Appeal Form must be properly completed and submitted with any supporting medical information that justifies the medical necessity, or appropriateness of the service(s).
- The Hartford will provide a written response to the provider who submitted the pre-service appeal no later than 14 calendar days after receipt of the appeal form and any supporting medical information.

2) Post-Service Appeals

A post-service appeal is an appeal **subsequent to** the performance or issuance of services.

- A New Jersey Post-Service Appeal Form must be properly completed and submitted at least 45 calendar days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in Superior Court.
- The New Jersey Post-Service Appeal Form must be submitted with any supporting medical information that justifies the medical necessity, or appropriateness of the service(s).
- The Hartford will provide a written response to the provider who submitted the post-service appeal no later than 30 calendar days after receipt of the appeal form and any supporting medical information.

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Procura has a provider network that is available to you. As outlined in N.J.A.C. 11:3-4.8, the Procura 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 your penalty co-payment is waived when accessing a network provider.

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

- Magnetic Resonance Imaging (MRI)
- Computer Assisted Tomography (CT/CAT Scans)
- Needle Electromyography (needle EMG), H-reflex and nerve conduction velocity (NCV) tests *
- Somatosensory Evoked Potential (SSEP)
- Visual Evoked Potential (VEP)

- Brain Audio Evoked Potential (BAEP)
- Brain Evoked Potential (BEP)
- Nerve Conduction Velocity
- H reflex Study
- Electroencephalogram (EEG)
- Durable Medical Equipment with a cost or monthly rental in excess of \$300.00
- Prescription Drugs
- 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 through the decision point review or precertification process, information about accessing our voluntary network of providers will be supplied to both the injured party and the requesting provider. Those individuals who choose not to utilize the network may be assessed a penalty co-payment not to exceed 30% of the eligible charge. That penalty co-payment will be the responsibility of the injured party.

Below is the contact information for the Network for the below specified approved services:

- A. Prescription Drugs:
Cypress Care at (800) 419-7191 or at www.cypresscare.com.
- E. Diagnostic Imaging/Electrodiagnostic Testing:
Information regarding the Procura provider network is available to you at www.procura-inc.com or you may call (866) 212-4014.
- F. Durable Medical Equipment:
Information regarding the Procura provider network is available to you at www.procura-inc.com or you may call (866) 212-4014.
- G. Services, equipment or accommodations provided by an ambulatory surgery facility.
Information regarding the Procura provider network is available to you at www.procura-inc.com or you may call (866) 212-4014.

Information regarding Procura's provider network is available to you at www.procura-inc.com or you may call (866) 212-4014. Our provider network includes Procura providers as well as the Magnacare Network.

Assignment of Benefits

At our option, medical expense benefits under the policy may be assigned to a health care provider who complies with the requirements of decision point review and agrees that any disputed issued involving treatment or services provided to the eligible injured person must be resolved through the dispute resolution process. Failure on the part of a provider to comply with all decision point review requirements or the dispute resolution process will render any prior assignment of benefits under the policy null and void. If the provider accepts direct payment of benefits, the provider is required to hold harmless the insured and us for any reduction of payment for services caused by the provider's failure to comply with the terms of the insured's policy.

Please feel free to call me at 800.280.0555 for assistance with these state requirements.

Sincerely,

<Hartford Claims Rep >

EXHIBIT C**DECISION POINT REVIEW PROCESS AND PROCEDURES**

The Decision Point Review Program described herein includes prospective and concurrent review services to evaluate and make a determination of medical necessity of a setting, procedure or group of services/ procedures, using professional medical review criteria and treatment standards, New Jersey Care Paths/ treatment standards, medical expertise (including physician advisor and physician examiners), as necessary.

The Decision Point Review process begins with The Hartford's claims office referral of the DPR case to the Hartford DPR nurse, each referral including the following information: patient name, treating provider name, telephone number, and address, location, diagnosis, date of treatment, date of injury and payer information. The DPR nurse reviews service authorization requests utilizing standard professional treatment protocols including the New Jersey Care Paths. Review of inpatient hospital services includes the review of the procedure necessity and the hospital admission. The DPR nurse certifies services which fall within a NJ Care Path or other treatment guideline. Where treatment does not fall within the relevant Care Path/treatment guideline, the DPR nurse may discuss an alternative plan with the attending physician or simply initiate referral to a physician reviewer. The DPR nurse completes the initial review within one business day and contacts the attending provider to a) authorize the service request, b) request additional information from the provider necessary to complete the authorization, or c) provide notice that a physician referral has been initiated.

Physician Referrals

If the service authorization request does not comply with the New Jersey defined Care Paths or other relevant professional medical necessity standards, the Decision Point Review nurse will utilize one of two potential physician referral options: 1) referral for a physician adviser review or 2) referral for an Independent Medical/Consultative Examination (ICE). The DPR nurse will make the referral appropriate to the individual case, subject to the approval of The Hartford claims office.

Peer Review

The Hartford may refer the service authorization request to a physician advisor (PA) for peer review, which review may include peer-to-peer consultation and negotiation. The Hartford obtains its physician advisor through a contract with the First MCO organization. The Hartford's DPR nurse will electronically refer a request to a PA of the same or similar specialty as typically manages the medical condition. The DPR nurse will provide the PA with the available claimant medical information and with other information necessary to the medical necessity determination. The PA may initiate peer-to-peer discussion with the treating physician as necessary to clarify the authorization request and to consider any medically appropriate alternative. The PA will make reasonable efforts to directly talk with the treating physician prior to any denial of authorization. The physician advisor will provide his decision to the DPR nurse who will in turn inform Hartford staff, treating provider, claimant and/or claimant representative within three business days.

Independent Consultative Examination (ICE)

The second physician referral option is the procurement of a third party independent consultative exam (ICE) in accordance with Rule 11:3-4.7(b) (2). The DPR nurse will refer the case to the First MCO organization to an ICE specialist qualified to treat/review the condition. The ICE specialist will coordinate the exam and prepare the necessary documentation. The ICE specialist will ensure that the exam is scheduled within seven (7) calendar days and otherwise conducted in a manner consistent with applicable state law/regulations. The ICE specialist will provide written documentation within three business days of completion of the examination. Communication of

results will be forwarded to the DPR nurse, the Hartford's nurse, and to the claim handler with a copy to the treating provider, claimant and/or claimant representative.

Appeals

The Hartford's process allows a treating provider who receives a denial or modification of authorization to submit an internal appeal of the decision.

There are two types of internal appeals:

1) Pre-Service Appeals

A pre-service appeal is an appeal of a decision point review and/or pre-certification 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").

- A New Jersey Pre-Service Appeal Form must be submitted no later than 30 calendar days after receipt of a written denial or modification of requested services.
- The New Jersey Pre-Service Appeal Form must be properly completed and submitted with any supporting medical information that justifies the medical necessity, or appropriateness of the service(s).
- The Hartford will provide a written response to the provider who submitted the pre-service appeal no later than 14 calendar days after receipt of the appeal form and any supporting medical information.

2) Post-Service Appeals

A post-service appeal is an appeal **subsequent to** the performance or issuance of services.

- A New Jersey Post-Service Appeal Form must be properly completed and submitted at least 45 calendar days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in Superior Court.
- The New Jersey Post-Service Appeal Form must be submitted with any supporting medical information that justifies the medical necessity, or appropriateness of the service(s).
- The Hartford will provide a written response to the provider who submitted the post-service appeal no later than 30 calendar days after receipt of the appeal form and any supporting medical information.

The New Jersey Pre-Service and Post-Service Appeals Forms (which are available on the New Jersey Department's website) should be submitted to The Hartford via facsimile at 866-771-6001 (same fax# to initiate a Decision Point Review with The Hartford). The Hartford will not accept any pre-service or post-service appeals that are not submitted within the required timeframes, submitted without the required supporting documentation or without the forms established by the Department by Order in accordance with N.J.A.C. 11:3-4.7(d).

Providers are only required to file a one-level internal appeal, for each appealable issue. That is, each appealable issue shall only be required to receive one internal appeal review prior to 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 amount the insurer should reimburse the provider for that same service. However, providers cannot request alternate dispute resolution without first having utilized the internal appeals process.

If you wish to appeal this matter further, you may do so in accordance with applicable law. You may contact your Hartford claim handler for assistance.

EXHIBIT D

SAMPLE DETERMINATION AND APPEALS NOTICE LETTERS

ADMINISTRATIVE NON-CERTIFICATION DUE TO LACK OF INFORMATION LETTER

(Current Date)

(Requestor)
(Street Address)
(City, State, Zip Code)

Re: Injured Person: (Patient's First Name, Last Name)
Claim No.: (Claim File Number)
Date of Injury: (Event Date of Injury)
Date of Birth: (Patient's Birth Date)

On two (2) separate occasions you/your office were contacted and requested to provide the necessary information for The Hartford's Decision Point Review Program to make an appropriate review determination.

(SO CPT Description)

(SO Reason(s) for non-certification: indicate what information is needed to make an appropriate review such as:

- 1) medical necessity of treatment/procedure not substantiated by documentation;**
- 2) no response to request for documentation of medical necessity; or**
- 3) treatment plan not clearly documented)**

Additional Text: includes type of service (e.g. Non-Emergency Inpatient Admission or Continued Stay Inpatient Days; Total # of days covered; Date of contact attempts)

The medical service(s) listed above is non-certified due to the lack of necessary information to conduct an appropriate review. If you disagree with this non-certification due to lack of information determination, you may call to discuss and/or submit the above requested information along with supporting documentation to the fax number listed below.

This applies only to the specific service(s) listed above. Additional services will require a separate review process.

This review determination was made to enable the Personal Injury Protection payer to fulfill its responsibility to furnish the medical services necessary for care and treatment of the injured person's covered injury. The treating medical provider(s) remain responsible for the medical care and treatment of the injured person.

(Designated Nurse Reviewer Name)
(Nurse Reviewer Title)
(800.280.0555)
(Fax Number) 866.771.6001

CC: (May include, but not limited to, treating/attending or other ordering provider, facility rendering service(s), Hartford claim handler, or other appropriate party)

SAMPLE APPROVAL LETTER

(Current Date)

(Requestor)
(Street Address)
(City, State, Zip Code)

Re: Injured Person: (Patient's first name, last name)
Claim #: (Claim File number)
Date of Injury: (Event date of injury)

The request for certification of the medical service(s) listed below is approved in accordance with applicable state law and regulations:

(SO CPT Description)
(SO Start Date), (SO End Date)
(Additional Text: includes type of service, such as Non-Emergency Inpatient Admission or Continued Stay Inpatient Days, total # of days covered, etc.)

Decision Point Review Program professional review staff has determined this specific medical service meets established criteria for medical necessity and appropriateness based on the information presented. The above review determination was based on: 1) standardized clinical review criteria and treatment standards, developed by physicians utilizing current clinical research and standards of practice recommended by reputable healthcare professional and institutional organizations and by the federal government, and 2) any treatment guidelines mandated by jurisdictional law and regulations specifically, the New Jersey Care Paths.

This certification applies only to the specific service(s) listed above. Additional services will require separate review.

Please note that, as indicated in the Hartford Fire Insurance Company DPR Plan, a benefit made available to the insured is the Voluntary Network Program (VNP) for durable medical equipment, prescription medication, diagnostic testing (MRI, CAT Scan and Electrodiagnostic studies) and Ambulatory Surgery facilities. The insured may be assessed a 30% copayment penalty for failure to utilize an In-Network Provider for the above approved testing(s), and / or durable medical equipment and Ambulatory Surgery facilities. Please contact us if you are in need of an additional copy of the DPR Plan. You or the insured may access the two specific Networks for the below specified services:

- A. Prescription Drugs:
Cypress Care at (800) 419-7191 or at www.cypresscare.com.
- B. Diagnostic Imaging/Electrodiagnostic Testing:
Information regarding the Procura provider network is available to you at www.procura-inc.com or you may call (866) 212-4014.
- C. Durable Medical Equipment:
Information regarding the Procura provider network is available to you at www.procura-inc.com or you may call (866) 212-4014.

- D. Services, equipment or accommodations provided by an ambulatory surgery facility.
Information regarding the Procura provider network is available to you at
www.procura-inc.com or you may call (866) 212-4014.

This letter is an authorization of the medical necessity and appropriateness for a specific requested service prior to performance of that service. This letter is not a guarantee of payment for all billed charges nor is it a guarantee of compensability/eligibility.

The Hartford Decision Point Review Program will concurrently review the progress of this injured person as necessary. Please contact The Hartford Nurse Reviewer at the telephone number listed below if you have any questions regarding this certification determination or regarding Utilization Management Program services.

(Designated Nurse Reviewer Name) (Nurse Reviewer Title)
(800.280.0555)
(fax number) 866.771.6001

CC: May include, but not limited to, facility rendering service(s), treating/attending or other ordering provider, Hartford claim handler, injured person or their representative when required by state law/regulations or upon request, or other appropriate party).

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SAMPLE NON-CERTIFICATION LETTER

(Current date)

(Requestor)
(Street Address)
(City, State, Zip Code)

Re: Injured Person: (Patient's First Name, Last Name)
Claim #: (Claim File Number)
Date of Injury: (Event Date of Injury)

The request for certification of the medical service(s) listed below has been reviewed in accordance with applicable state law and regulations by a qualified physician advisor identified below:

(SO CPT Description)
(SO Start Date), (SO End Date)

(SO Reason(s) for non-certification – including a brief clinical basis for non-certification)

(Additional Text: includes type of service, such as Non-Emergency Inpatient Admission or Continued Stay Inpatient Days, total # of days covered; Peer reviewer's name and contact info)

The physician advisor has determined based on review of the provided documentation and discussion with the treating provider that this specific medical service was not medically necessary and/or appropriate. In making this determination, the physician advisor utilized: 1) standardized clinical review criteria and treatment standards, developed by physicians utilizing current clinical research and standards of practice recommended by reputable healthcare professionals and institutional organization and by the federal government, and 2) any treatment guidelines mandated by jurisdictional law and regulations (including the New Jersey Care Paths).

The clinical rationale used in making this non-certification determination is available upon written request.

This review applies only to the specific service(s) listed above. Additional services will require separate review.

If you disagree with this decision, The Hartford's process allows you as the treating provider to submit an Internal Appeal – see below for further details.

There are two types of internal appeals:

1) Pre-Service Appeals

A pre-service appeal is an appeal of a decision point review and/or pre-certification 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").

- A New Jersey Pre-Service Appeal Form must be submitted no later than 30 calendar days after receipt of a written denial or modification of requested services.

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- The New Jersey Pre-Service Appeal Form must be properly completed and submitted with any supporting medical information that justifies the medical necessity, or appropriateness of the service(s).
- The Hartford will provide a written response to the provider who submitted the pre-service appeal no later than 14 calendar days after receipt of the appeal form and any supporting medical information.

2) Post-Service Appeals

A post-service appeal is an appeal **subsequent to** the performance or issuance of services.

- A New Jersey Post-Service Appeal Form must be properly completed and submitted at least 45 calendar days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in Superior Court.
- The New Jersey Post-Service Appeal Form must be submitted with any supporting medical information that justifies the medical necessity, or appropriateness of the service(s).
- The Hartford will provide a written response to the provider who submitted the post-service appeal no later than 30 calendar days after receipt of the appeal form and any supporting medical information.

The New Jersey Pre-Service and Post-Service Appeals Forms (which are available on the New Jersey Department's website) should be submitted to The Hartford via facsimile at 866-771-6001 (same fax# to initiate a Decision Point Review with The Hartford). The Hartford will not accept any pre-service or post-service appeals that are not submitted within the required timeframes, submitted without the required supporting documentation or without the forms established by the Department by Order in accordance with N.J.A.C. 11:3-4.7(d).

Providers are only required to file a one-level internal appeal, for each appealable issue. That is, each appealable issue shall only be required to receive one internal appeal review prior to 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 amount the insurer should reimburse the provider for that same service. However, providers cannot request alternate dispute resolution without first having utilized the internal appeals process.

If you wish to appeal this matter further, you may do so in accordance with applicable law. You may contact your Hartford claim handler for assistance.

This review determination was made to enable the Personal Injury Protection payer to fulfill its responsibility to furnish the medical services necessary for care and treatment of the injured person's covered injury. The treating medical provider(s) remain responsible for the medical care and treatment of the injured person.

(Designated Nurse Reviewer Name)
(Nurse Reviewer Title)
(800.280.0555)
(Fax Number) 866.771.6001

CC: (May include, but not limited to, facility rendering service(s), treating/attending or other ordering provider, Hartford claim handler, injured person or their representative when required by state law/regulation, or other appropriate party)

SAMPLE STANDARD APPEAL – OUTCOME REVERSED LETTER

(Current Date)
(Requestor)
(Street Address)
(City, State, Zip Code)

Re: Injured Person: (Patient's First Name, Last Name)
Claim #: (CCPS Claim File Number)
Date of Injury: (Event Date of Injury)

Your request for a standard appeal of the below-referenced review determination was submitted to a qualified physician advisor identified below: and who was not involved in the original review or expedited appeal determination of the medical necessity and/or appropriateness of the below-described service. This standard appeal consisted of reviewing the original information, any additional provided information, and supplemented by a statement from the treating physician and review of the applicable injured person's medical records.

(SO Service Being Appealed by CPT Description)

(Additional Text: includes the following –

Physician Advisor: (PA's First Name, Last Name)

This physician advisor has reversed the original determination, finding that the service in question is medically necessary and appropriate in this case.

Please feel free to contact The Hartford's Decision Point Review Program at the address or telephone number listed below for further information and/or concurrent/continued stay review.

(Designated Nurse Reviewer Name)
(Nurse Reviewer Title)
(Address)
(800.280.0555)
(Fax Number) 866.771.6001

CC: (May include, but not limited to, treating/attending or other ordering provider, injured person or their representative, facility rendering service(s), Hartford claim handler, or other appropriate party)

SAMPLE INDEPENDENT CONSULTATIVE EXAMINATION - TERMINATION LETTER

(Current Date)

(Requestor)
(Street Address)
(City, State, Zip Code)

Re: Injured Person: (Patient's First Name, Last Name)
Claim Number: (CCPS Claim File Number)
Date of Injury: (Event Date of Injury)

Please be advised that we have recently obtained an Independent _____ Consultative Examination with Dr. _____ on _____. Dr. _____ has determined that _____ has reached maximum medical improvement regarding injuries sustained on the above date of loss.

Based on the results of this independent consultative examination, The Hartford will not reimburse for any further medical treatment, diagnostic testing or durable medical equipment for specific diagnosis and related diagnoses which prompted this <insert Specialty of ICE exam, such as if Orthopedic ICE, etc.> _____ ICE as of <insert date 7 days from date of letter>

The results of the ICE do not necessarily mean that the person is no longer entitled to wage loss or essential service benefits, only that the person has reached maximum medical improvement and that future medical treatment, diagnostic testing or durable medical equipment which prompted this ICE are no longer warranted.

Please contact me at the toll-free number listed below should you have questions.

(Name of Designated Claim Representative)
Claim Representative
(Address)
Toll-free phone number: (800.280.0555)
Fax number: (866.771.6001)

CC: (May include, but not limited to, treating/attending or other ordering provider, injured person or their representative, facility rendering service(s), Hartford claim handler, or other appropriate party)

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SAMPLE INDEPENDENT CONSULTATIVE EXAMINATION -
SCHEDULE APPOINTMENT LETTER

(Current Date)

(Injured Person / Requestor)
(Street Address)
(City, State, Zip Code)

Re: Injured Person: (Patient's First Name, Last Name)
Claim Number: (CCPS Claim File Number)
Date of Injury: (Event Date of Injury)

This letter is being sent to let you know that you have been scheduled for an Independent Consultant Examination (ICE) to evaluate the Decision Point Review request of <insert name> _____. The examination is scheduled for <insert date _____> at <insert time _____> with the following physician:

<Insert name of Physician>
<Insert street address> ____
<Insert city, state, zip> ____
<Insert telephone number>

You are required to supply all medicals, including any and all X-rays, CT Scans and/or MRI films and reports at the time of the exam or prior to the exam. Also, please bring a photo ID along with you for identification purposes. Failure to supply requested medical information may be treated as an unexcused absence. Two unexcused failures to attend the scheduled ICE may result in notification to you and your treating provider(s) that no reimbursement will be made for all further treatment, diagnostic testing or durable medical equipment relating to the diagnosis code(s) contained in the request or attending provider treatment plan form that necessitated the schedule of this ICE, regardless of medical necessity.

If you are unable to make this ICE, please notify me no less than twenty-four (24) hours prior to the date and time of the scheduled ICE.

If you have any questions, please contact the undersigned at the toll-free telephone number listed below.

(Name of Designated Claim Representative)
Claim Representative
Toll-free Number: 800.280.0555
Fax Number: 866.771.6001

Writing Company: (insert name of Hartford writing company)

CC: (May include, but not limited to, treating/attending or other ordering provider, injured person or their representative, facility rendering service(s), Hartford nurse reviewer, or other appropriate party)

SAMPLE INDEPENDENT CONSULTATIVE EXAMINATION - 1st NO SHOW LETTER

(Current Date)

(Injured Person / Requestor)
(Street Address)
(City, State, Zip Code)

Re: Injured Person: (Patient's First Name, Last Name)
Claim Number: (CCPS Claim File Number)
Date of Injury: (Event Date of Injury)

This letter is being sent to advise you that you failed to attend the Independent Consultative Examination (ICE) that was scheduled for <insert date> to evaluate the Decision Point Review request of <insert name >. The examination has been rescheduled for <insert date> at <insert time> with the following physician:

<Insert name of Physician>
<Insert street address> __
<Insert city, state, zip> __
<Insert telephone number>

In addition to a photo ID, you are required to supply all medicals, including any and all X-rays, CT Scans and/or MRI films and reports at the time of the exam or prior to the exam. Failure to supply requested medical information may be treated as an unexcused absence. Your unexcused failure to attend the scheduled ICE may result in notification to you and your treating provider(s) that no reimbursement will be made for all further treatment, diagnostic testing or durable medical equipment relating to the diagnosis code(s) contained in the request or attending provider treatment plan form that necessitated the schedule of this IME, regardless of medical necessity.

If you are unable to make this ICE, please notify me no less than twenty-four (24) hours prior to the date and time of the scheduled ICE.

If you have any questions, please contact the undersigned at the toll-free telephone number listed below.

(Name of Designated Claim Representative)
Claim Representative
Toll-free Number 800.280.0555
Fax Number: 866.771.6001

Writing Company: (insert name of Hartford writing company)

CC: (May include, but not limited to, treating/attending or other ordering provider, injured person or their representative, facility rendering service(s), Hartford nurse reviewer, or other appropriate party)

SAMPLE INDEPENDENT CONSULTATIVE EXAMINATION - 2nd NO SHOW/CUTOFF LETTER

(Current Date)

(Injured Person / Requestor)
(Street Address)
(City, State, Zip Code)

Re: Injured Person: (Patient's First Name, Last Name)
Claim Number: (CCPS Claim File Number)
Date of Injury: (Event Date of Injury)

You failed to attend Independent Consultative Examinations (ICEs) scheduled on <insert date _____> and <insert date _____>. In accordance with terms of your No-Fault policy and the New Jersey Decision Point Review Plan, you were notified that two unexcused failures to attend an ICE may result in the denial of requested services for related diagnoses, regardless of medical necessity.

As you failed to attend the scheduled ICE on more than one occasion, we will be unable to authorize or pay for any further treatment, diagnostic testing or durable medical equipment relating to the following diagnosis and related diagnoses as of <insert date _____>:

<Insert item: Diagnostic testing >

If you have any questions, please contact the undersigned at the toll-free telephone number listed below.

(Name of Designated Claim Representative)
Claim Representative
Toll-free Number: 800.280.0555
Fax Number: 866.771.6001

Writing Company: (insert name of Hartford writing company)

CC: (May include, but not limited to, treating/attending or other ordering provider, injured person or their representative, facility rendering service(s), Hartford nurse reviewer, or other appropriate party)

TRANSITION PLAN

The Hartford’s Decision Point Review Program provides a transition plan to comply with N.J.A.C. 11:3-4.1 et seq.

The Hartford will send the following notice to both the claimant and all providers on open NJ Personal Injury Protection claims to notify them of the changes to our plan.

SAMPLE TRANSITION PLAN ‘NOTICE OF CHANGES’

(Current Date)

(Name)
(Street Address)
(City, State, Zip Code)

Re: Injured Person: (Patient’s First Name, Last Name)
Claim Number: (CCPS Claim File Number)
Date of Injury: (Event Date of Injury)

Dear (Name);

Please be advised that The Hartford’s Decision Point Review Plan has been amended to replace our previously filed Appeals Process with the new Internal Appeals process outlined in N.J.A.C. 11:3-4.7(b). This new process applies to all appeals filed on or after April 17, 2017.

The Internal Appeals process allows a treating provider who receives a denial or modification of authorization to submit an internal appeal of the decision.

There are two types of internal appeals:

1) Pre-Service Appeals

A pre-service appeal is an appeal of a decision point review and/or pre-certification 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”).

- A New Jersey Pre-Service Appeal Form must be submitted no later than 30 calendar days after receipt of a written denial or modification of requested services.
- The New Jersey Pre-Service Appeal Form must be properly completed and submitted with any supporting medical information that justifies the medical necessity, or appropriateness of the service(s).
- The Hartford will provide a written response to the provider who submitted the pre-service appeal no later than 14 calendar days after receipt of the appeal form and any supporting medical information.

2) Post-Service Appeals

A post-service appeal is an appeal **subsequent to** the performance or issuance of services.

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- A New Jersey Post-Service Appeal Form must be properly completed and submitted at least 45 calendar days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in Superior Court.
- The New Jersey Post-Service Appeal Form must be submitted with any supporting medial information that justifies the medical necessity, or appropriateness of the service(s).
- The Hartford will provide a written response to the provider who submitted the post-service appeal no later than 30 calendar days after receipt of the appeal form and any supporting medical information.

The New Jersey Pre-Service and Post-Service Appeals Forms (which are available on the New Jersey Department's website) should be submitted to The Hartford via facsimile at 866-771-6001 (same fax# to initiate a Decision Point Review with The Hartford). The Hartford will not accept any pre-service or post-service appeals that are not submitted within the required timeframes, submitted without the required supporting documentation or without the forms established by the Department by Order in accordance with N.J.A.C. 11:3-4.7(d).

Providers are only required to file a one-level internal appeal, for each appealable issue. That is, each appealable issue shall only be required to receive one internal appeal review prior to 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 amount the insurer should reimburse the provider for that same service. However, providers cannot request alternate dispute resolution without first having utilized the internal appeals process.

These changes will apply to all appeals received on or after April 17, 2017.

Name of Designated Claim Representative)
Claim Representative
Toll-free Number: 800.280.0555
Fax Number: 866.771.6001

Writing Company: (insert name of Hartford writing company)

CC: (May include, but not limited to, treating/attending or other ordering provider, injured person or their representative, facility rendering service(s), Hartford nurse reviewer, or other appropriate party)