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DECISION POINT REVIEW PLAN REQUIREMENTS

IMPORTANT INFORMATION ABOUT YOUR NO-FAULT MEDICAL COVERAGE AND REIMBURSEMENT

Please read this information carefully and share it with your treating health care providers.

In 1998 New Jersey enacted the Automobile Insurance Cost Reduction Act became law and as a result there were established obligations which you must satisfy for coverage of medically necessary treatment, diagnostic testing and durable medical equipment arising from injuries sustained in an automobile accident. During the course of your claim, you may be contacted by our PIP vendor, Prizm, LLC as it relates to obligations you have while receiving medical treatment for your injuries and any subsequent bills. This contact may include, but isn't limited to your obligation to attend an Independent Medical Examination. Failure to abide by the following obligations may affect the authorization for medical treatment, diagnostic testing and durable medical equipment.

This document serves as AIG's Decision Point Review and Pre-Certification Plan in accordance with NJAC 11:3-4.7 and NJAC 11:3-4.8.

Prizm, LLC has been selected by AIG to implement their plan as required by the Automobile Cost Reduction Act. Prizm will review treatment plan requests for Decision Point Review/Precertification, perform Medical Bill Repricing and Audits of Provider bills, coordinate Independent Medical Exams and Peer Reviews, and provide Case management Services.

AIG's Personal injury protection coverage shall provide reimbursement for all medically necessary expenses for the diagnosis and treatment of injuries sustained from a covered automobile accident up to the limits set forth in the policy and in accordance with NJ personal injury regulations. "Medically necessary" or "medical necessity" means that the medical treatment or diagnostic test is consistent with the clinically supported symptoms, diagnosis or indications of the injured person, and:

- The treatment is the most appropriate level of service that is in accordance with the standards of good practice and standard professional treatment protocols consisting of evidence-based clinical guidelines/practice/treatment published in peer-reviewed journals;
- The Care Paths in the Appendix, as applicable;
- The treatment of the injury is not primarily for the convenience of the injured person or provider; and
- Does not include unnecessary testing or treatment. "Standard professional treatment protocols"

As it relates to this Decision Point Review Plan "Business hours" are defined as Monday through Friday, between the hours of 8:00 AM and 5:00 PM, EST, except for federally and/or State Declared Holidays and New Jersey Declared State of Emergencies where travel is prohibited,

As it relates to this Decision Point Review Plan, the following applies when "Days" are referenced:

- "Days" means calendar days unless specifically designated as business days.
- A calendar and business day both end at the time of the close of business hours.
- 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 days 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.

Response on Decision Point Review and Precertification requests must be communicated to the treating provider no later than three (3) business days after the submitted request. **Example:** A provider submits a proper request on Monday at 6:00 PM, which is one (1) hour after the close of business hours at 5:00 PM. A response is due back to the treating provider no later than Friday at the close of the business hours.

Decisions on pre-service appeals shall be communicated to the provider no later than fourteen (14) days from the date the insurer receives the appeal. **Example:** The insurer receives the appeal by facsimile; transmission dated 3:00 P.M. on Tuesday, January 8. Day one (1) of the fourteen (14) day period is Wednesday, January 9. The 14th day would be Tuesday, January 22, however there is a State of Emergency Declared in New Jersey on Tuesday January 22nd due to inclement weather. The insurer's decision is due no later than Wednesday, January 23, providing the State of Emergency has been lifted.

Decisions on post-service appeals shall be communicated to the provider no later than thirty (30) days from the date the insurer receives the appeal. **Example:** The insurer receives the appeal by facsimile; transmission dated 3:00 P.M. on Tuesday, June 28. Day one (1) of the thirty (30) day period is Wednesday, June 29. The 30th day would be Friday, July 29, as July 4 is a federally declared holiday.

No Decision Point or precertification requirements shall apply within ten (10) days of the injured party's event or to treatment administered in emergency care as stated in NJAC 11:3-4.7. Such treatment shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.

Informational materials for policyholders, injured parties and providers shall be on forms approved by the Commissioner as stated in NJAC 11:3-4.4. These materials will be distributed by AIG at policy issuance, renewal and upon notification of the claim. Additionally, these materials will be available at the insurer's Web Site. These materials will include:

- How to contact AIG or Prizm to submit decision point review/pre-certification requests including telephone, fax numbers, and email addresses.
- An explanation of the Decision Point Review process/Pre-Cert Process including a list of the identified injuries and the diagnostic tests (NJAC 11:3-4.5. The materials shall also include copies of the Care Paths or indicate how copies can be obtained. Additionally, the web site will include the list of voluntary networks with their telephone, fax and email addresses.)
- A list of the medical services that require pre-certification
- An explanation of how AIG will respond to decision point review/pre-certification requests, including time frames. The materials should indicate:
    - Telephonic responses will be followed with a written authorization, denial or request for more information within three (3) business days.
- An explanation of the penalty co-payments imposed for the failure to submit decision point review/pre-certification requests where required or failure to provide clinically supported findings that support the treatment, diagnostic tests or durable medical goods in accordance with NJAC 11:3-4.4
- An explanation and certification of the *AIG* voluntary network for certain types of testing, durable medical equipment and prescription drugs authorized by NJAC 11:3-4.4
- An explanation of the alternatives available to the provider if reimbursement for a proposed treatment or test is denied or modified, including the internal appeals process and how to use it.
- An explanation of the *AIG* restriction on assignment of benefits, if any.

If Prizm on behalf of AIG fails to respond to a request for decision point review/pre-certification three (3) business days after the time it is received by AIG or Prizm, the treatment, testing or durable medical equipment may proceed until AIG or Prizm notifies the provider that reimbursement for the treatment or testing is not authorized.

Decision Point Review Process and Obligations

1. Insured or injured party is obliged to notify AIG at the time of injury. Contact information is provided to the insured by AIG in their policy information. Once AIG is notified of injuries, the claims handler will contact the injured party to explain the Decision Point Review/Pre-Certification process and obtain the facts surrounding the injury. The claims handler via mail forwards a notification packet to the injured party or designee and any named medical providers.

2. Provider is obliged to contact AIG or its designated vendor, once treatment that is subject to Decision Point Review or Pre-Certification is initiated. The provider contacts Prizm at 856-596-5600 phone, by fax at 856-596-6300, or electronically at Documents@Prizmllc.com or by accessing Prizm's web address at www.Prizmllc.com.

- All treating providers are required to submit all requests on the "Attending Provider Treatment Plan" for Decision Point Review and Precertification treatment requests. A copy of this form can be found on the NJDOBI web site www.nj.gov/dobi/aicrapg.htm or at Prizm's web site www.Prizmllc.com.
- Failure to submit a completed Decision Point Review and Precertification treatment request, including but not limited to a completed "Attending Provider Treatment Plan" and legible clinically supported record will result in the submitting provider being notified, three (3) business days after the incomplete submission of what is needed to complete the precertification submission.
- Providers who submit Decision Point Review/Precertification are those providers who, in part, physically and personally perform evaluations of the injured persons condition, state the specific treatment and set treatment goals. AIG will not accept Decision Point Review/Precertification requests from the following providers:
    - Hospitals
    - Radiologic Facilities
    - Durable Medical Equipment Companies
    - Ambulatory Surgery Centers
    - Registered bio-analytical laboratories;
    - Licensed health maintenance organizations;
    - Transportation Companies
    - Suppliers of Prescription drugs/Pharmacies

If any of the above restricted providers submits a Decision Point Review/Precertification request Prizm will respond to them no later than three (3) business days after the receipt of the request informing that they are a restricted provider and instruct them that the submission must be made by the referring/treating provider.

3. A decision to the provider's request for treatment/test/Durable Medical Equipment will be communicated three (3) business days after the treatment request is received by AIG or Prizm. This decision is communicated to the requesting provider by fax or mail during business hours. If another business or entity faxes an Attending Provider Treatment Plan form to Prizm, or requests notification of decision regarding requests for pre-certification, that business or entity will not receive same; Notifications will strictly be sent to the provider identified on the Attending Provider Treatment Plan who requested the specified treatment, testing, or Durable Medical Equipment.

4. Failure to request decision point review or pre-certification where required or failure to provide clinically supported findings that support the treatment, test or durable medical equipment requested shall result in an additional copayment of 50% of the eligible charge for medically necessary diagnostic tests, treatments or durable medical goods that were rendered between the time notification to AIG was required and when Prizm communicates the decision three (3) business days after the receipt of the treatment request. Such treatment shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.

5. In accordance with NJAC 11:3-4.7:

- Denials of decision point review and pre-certification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist.
- If AIG or Prizm fails to respond to the request three (3) business days after the receipt of the necessary information, the treating provider may continue the test, course of treatment, or durable medical equipment until such time as the final determination is communicated to the provider.
- The treating provider must be notified of the decision after the stated three (3) business days by fax or mail (as defined by date of postmark)

Decisions:

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- Approved: A request for treatment/testing/Durable Medical Equipment is approved by either the Nurse or a Physician Advisor (if forwarded to a Physician Reviewer) or as a result of an Independent Medical Examination.
- Denied: A request for treatment/testing/Durable Medical Equipment is denied either by a Physician Advisor or an Independent Medical Examiner.
- Modified: A request for treatment/testing/Durable Medical Equipment is modified either by a Physician Advisor or an Independent Medical Examiner.
- Administrative Denial: Failure to submit "Attending Provider Treatment Plan" or an incomplete Decision Point Review and Precertification treatment request , including but not limited to an incomplete "Attending Provider Treatment Plan" and legible clinically supported record will result in the submitting provider being notified three (3) business days after the incomplete submission of what is needed to complete the precertification submission Upon receipt of the required additional information, the completed request will be reviewed and a decision will be rendered three (3) business days after the submission.
- Retrospective DOS: If the request for treatment/testing/Durable Medical Equipment is for a Date of Service which has already occurred, a decision of Retrospective DOS will be rendered.
- Pended to IME: If based-on the Physician Advisor's opinion a physical or mental examination is needed to render a decision, an appointment for an IME (of the same discipline and the most appropriate specialty related to the treating diagnoses) at a location reasonably convenient location to the examinee is scheduled within seven (7) calendar days of the date of the request. It is noted that medically necessary treatment can continue while the IME is being scheduled Such treatment shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.
- Restricted: Provider prohibited from submitting Decision Point Review/Precertification. Provider will be instructed that the submission must be made by the referring/treating provider.
- Previously Requested: If the requested treatment/testing/Durable Medical Equipment has already been requested by the same provider (DOS and CPT codes) or an ancillary provider (related CPT codes to primary procedure, i.e., anesthesia for surgery) a decision of previously requested will be entered and the decision of the previously requested service will be forwarded to the provider submitting the request.

- If Prizm**,** on behalf of the insurer, does not respond to the request within three (3) business days of receipt of the necessary information, the provider may proceed with the treatment, test, or durable medical equipment until such time as a final determination is communicated to the provider.
- Prizm shall notify the injured person or designee if a physical examination is required to determine the medical necessity of further treatment, test, or durable medical equipment.
- If a physical or mental examination is required, the appointment will be scheduled within seven (7) calendar days of the date of the request for the treatment, test or durable medical equipment unless the injured person/designee agrees to extend the time period.
- If based on the Physician Advisor's opinion a physical or mental examination is needed to render a decision, an appointment for an IME (of the same discipline and within a location reasonably convenient to the patient) is scheduled within seven (7) calendar days of the date of the request. It is noted that medically necessary treatment can continue while the IME is being scheduled.
- Prizm on behalf of AIG shall notify by mail the injured person or his designee and shall notify by fax the requesting provider whether reimbursement for further treatment or test is authorized as promptly as possible, but no later than three (3) business days after the examination.
- The IME shall be scheduled with a provider of the same discipline and the most appropriate specialty related to the treating diagnoses as the treating provider and within a location reasonably convenient to the patient**.** The injured person, upon the request of *AIG*, shall 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.
- If the injured party being examined does not speak English, they must contact AIG who may be able to arrange English Speaking Interpreter provided to them. They can also provide their own Interpreter at their own cost.
- Treatment may continue with the treating provider until the results of the IME are available, however only medically necessary care will be reimbursed. Such treatment shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.

- Prizm shall notify the treating provider whether reimbursement for further treatment or testing is authorized as promptly as possible, but no later than three (3) business days after the examination. The injured party/designee and the treating provider shall be entitled to a copy of the IME report upon request
- A copy of the examining physician's report is available upon request.

Unexcused Failure to Attend a Scheduled Physical Exam

Prizm will notify the injured party or designee and the treating provider of the scheduled physical examination and of the consequences for unexcused failure to appear at two or more appointments. If the injured party has two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to the injured person or his or her designee, and all the providers treating the injured person for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form. This notification will place the injured person on notice that all future treatment diagnostic testing or durable medical equipment required for the diagnosis and (related diagnosis) contained in the attending physicians treatment plan form will not be reimbursable as a consequence for failure to comply with the plan.

After an unexcused failure to attend a scheduled physical exam, AIG will send a notification (by mail or fax) to the insured or their designee and all treating providers for the diagnosis (and related diagnosis) contained in the Attending Provider Treatment Plan form advising them of the consequences (cessation of reimbursement for future treatment/tests/durable medical equipment) for unexcused failure to attend the second scheduled examination.

The flowing will constitute an unexcused failure:

- Failure of the Injured Party to attend a scheduled IME without proper notice to Prizm
- Failure of the Injured party to notify Prizm at least two (2) days prior to the IME date
- Any reschedule of an unattended IME that exceeds thirty-five (35) calendar days from the date of the original IME, without permission from *AIG*.
- Failure to provide requested medical records, including radiology films, at the time of the IME
- If the injured party being examined does not speak English, and they failed to request or provide an English speaking interpreter for the exam.

AIG will notify the treating provider by fax or mail if the injured party has a second unexcused failure to attend the IME. This notification will state no further reimbursement can be made.

DECISION POINT REVIEW/PRECERTIFICATION REQUESTS

In accordance with N.J.A.C. 11:3-4.5, the administration of any of the following diagnostic tests is subject to Decision Point Review, regardless of diagnosis:

Diagnostic Tests which are subject to Decision Point Review according to N.J.A.C. 11:3-4.5

- Needle Electromyography (EMG)
- Somatosensory Evoked Potential (SSEP)
- Visual Evoked Potential (VEP)
- Brain Audio Evoked Potential (BAEP)
- Brain Evoked Potentials (BEP)
- Nerve Conduction Velocity (NCV)
- H-Reflex Studies
- Electroencephalogram (EEG)
- Videofluroscopy
- Magnetic Resonance Imaging (MRI)
- Computer Assisted Tomograms (CT, CAT Scan)

- Dynatron/Cybex Station/Cybex Studies
- Sonogram/Ultrasound
- Brain Mapping
- Thermography/Thermograms

The following list includes treatment, test and medical services that are subject to Pre-Certification according to Prizm's Plan:

- Non-emergency inpatient and outpatient hospital care
- Non-emergency surgical procedures
- Infusion Therapy
- Extended Care Rehabilitation Facilities
- All Outpatient care for soft-tissue/disc injuries of the person's neck, back and related structures not included within the diagnoses covered by the Care Path's.
- All Physical, Occupational, Speech, Cognitive, Rehabilitation or other restorative therapy or therapeutic or body part manipulation except that provided for identified injuries in accordance with decision point review including but not limited to re-evaluations.
- All Outpatient psychological/psychiatric treatment/testing and/or services
- All pain management/pain medicine services except as provided for identified injuries in accordance with decision point review
- Home Health Care
- Acupuncture
- Durable Medical Equipment (including orthotics and prosthetics), with a cost or monthly rental, in excess of $100.00
- Non-Emergency medical transport with a round trip transportation in excess of $100
- Non-Emergency Dental Restorations
- Temporo-mandibular disorders; any oral facial syndrome
- Current Perception Testing
- Computerized Muscle Testing
- Nutritional Supplements
- All treatment and testing related to balance disorders
- Bone Scans
- Podiatry
- Urine drug testing for prescription management or drug abuse identification
- Prescription Drugs costing more than $100.00
- Any procedures that use an unspecified CPT/CDT, DSM IV, and/or HCPCS code

Treating providers are encouraged to submit their requests in an effort to establish an agreed upon voluntary comprehensive treatment plan for all of a covered person's injuries to minimize the need for piecemeal review. Reimbursement for treatment, testing or Durable Medical Equipment consistent with the consensual treatment plan will be made without review or audit.

AIG shall not retrospectively deny payment for treatment, diagnostic testing or durable medical equipment on the basis of medical necessity where a decision point review or precertification request for that treatment or testing was properly submitted to the insurer unless the request involved fraud or misrepresentation by the provider or the person receiving the treatment, diagnostic testing or durable medical equipment.

New Jersey Personal Injury Protection Law prohibits reimbursement for the following tests;

- Spinal diagnostic ultrasound;
- Iridology;
- Reflexology;
- Surrogate arm mentoring;

- Surface electromyography (surface EMG);
- Mandibular tracking and stimulation
- Any other diagnostic tests that is determined by New Jersey Law or regulation to ineligible for Personal Injury Protection Coverage

New Jersey Personal Injury Protection Law prohibits reimbursement for the following treatment:

- Kinesio Tape
- X-ray Digitization
- Any other treatment/test tests that is determined by New Jersey Law or regulation to ineligible for Personal Injury Protection Reimbursement

Pursuant to N.J.A.C. 13:30-8.22(b), the personal injury protection medical expense coverage shall not provide reimbursement for the following diagnostic tests which have been identified by the New Jersey State Board of Dentistry as failing to yield data of sufficient volume to alter or influence the diagnosis or treatment plan employed to treat TMJ/D:

- Mandibular tracking;
- Surface EMG;
- Sonography;
- Doppler ultrasound;
- Needle EMG;
- Electroencephalogram (EEG);
- Thermograms/thermographs;
- Video fluoroscopy; and
- Reflexology.
- Any other treatment/test tests that is determined by New Jersey Law or regulation to ineligible for Personal Injury Protection Reimbursement

1. In accordance with NJAC 11:3-4.7B, Prizm's appeal process is as follows:
   A. Pre-service appeals
      i. If a request for medical services is denied or modified by a Physician Advisor Review or an IME, the treating provider must request a reconsideration of the physician recommendation prior to the performance or issuance of the requested service. This request must be made in writing within 30 days of receipt of the recommendation to deny the DPR or Pre-certification request. The request must include a properly completed Pre-Service Appeal Form (as defined in section ii below) in accordance with NJAC 11:3-4.7(d), the original Attending Provider Treatment Plan (APTP) being appealed, the APTP Decision/Response document being appealed, an appeal rationale narrative, the appeal physician's signature and reason(s) for reconsideration along with any additional supporting documentation. If the required information is not submitted at the time the pre-service appeal is received, the appeal will be denied administratively and will not be addressed. Provider will be notified of the insufficiencies contained in their appeal submission and will be given the opportunity to resubmit correctly.
      ii. A properly completed Pre-Service Appeal Form must include:
         - Date Appeal Submitted (box 1)
         - Receipt Date of Adverse Decision (box 2)
         - All Claim Information (boxes 3-5)
         - All Patient Information (boxes 6-13)
         - Provider/Facility Information (boxes 14-25)
         - Required Documents attached
            - Original APTP Form
            - APTP Decision/Response document
            - Appeal rationale narrative
            - Additional new supporting records
         - Pre-service Appeal Issues (boxes 30-34 as appropriate)

- Only one APTP should be submitted per Pre-Service Appeal Form. If multiple APTP's require a pre-service appeal, a separate Pre-Service Appeal Form should be submitted for each unique APTP.
- Signature of Provider (box 35)

iii. The properly completed Pre-Service Appeal Form and required attached documents should be submitted to Prizm via fax at (856) 596-6300, electronically at Documents@prizmllc.com or mailed to PO Box 5480, Mt. Laurel, NJ 08054.

iv. It may be determined that an Independent Medical Examination is necessary. If this is the case, the appointment shall be scheduled within seven (7) calendar days of receipt of the appeal request unless the injured person agrees to extend the time period. The examination shall be scheduled with a provider of the same discipline and the most appropriate specialty related to the treating diagnoses as the treating provider and within a location reasonably convenient to the patient.

v. Prizm's written response to the appeal will be communicated to the provider listed on the Pre-Service Appeal Form (boxes 14-25) by fax or mail within fourteen (14) days after of receipt of the appeal request and any supporting documentation.

B. Post-service appeals

i. If the appeal is for any issue, other than treatment denials or modifications done by a Physician Advisor Review or an IME, subsequent to the performance or issuance of the services, a treating provider must request reconsideration through Prizm. This request must be made in writing within 90 days of receipt of the explanation of benefits and at least 45 days prior to initiating alternate dispute resolution pursuant to N.J.A.C 11:3-5. The request must include a properly completed Post-Service Appeal Form in accordance with NJAC 11:3-4.7(d) (as defined in section ii below), the original Bill (HCFA/UB), the Explanation of Benefit/Payment, the signature of the treating provider and reason(s) for reconsideration along with any additional supporting documentation. If the required information is not submitted at the time the post-service appeal is received, the appeal will be denied administratively and will not be addressed. Provider will be notified of the insufficiencies contained in their appeal submission and will be given the opportunity to resubmit correctly.

ii. A properly completed Post-Service Appeal Form must include:
- Date Appeal Submitted (box 1)
- Receipt Date of Adverse Decision (box 2)
- All Claim Information (boxes 3-5)
- All Patient Information (boxes 6-13)
- Provider/Facility Information (boxes 14-25)
- Required Documents attached
  - Original Bill (HCFA/UB)
  - Explanation of Benefit/Payment
  - Appeal rationale narrative
- Post-service Appeal Issues (boxes 30-38 as appropriate)
  - Only one EOB ID should be submitted per Post-Service Appeal Form. If multiple EOB's require a post-service appeal, a separate Post-Service Appeal Form should be submitted for each unique EOB ID.
- Signature of Provider (box 39)

iv. The properly completed Post-Service Appeal Form and required attached documents should be submitted to Prizm via fax at (856) 596-6300, electronically at Documents@prizmllc.com or mailed to PO Box 5480, Mt. Laurel, NJ 08054.

vi. Prizm's written response to this appeal will be communicated to the requesting provider by fax or mail within thirty (30) days after the receipt of the appeal form and any supporting documentation.

C. One-Level Appeal Requirement

i. Each issue shall require one internal appeal submission prior to making a request for alternate dispute resolution. A request that has been denied administratively does not constitute an appeal. A pre-service 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 a post-service appeal of what the insurer should reimburse the provider for that same service. If a provider submits a

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pre-service appeal or the modification or denial of treatment by a Physician Advisor Review or an IME and subsequently performs the services and receives an EOB denial on the basis of the same PAR or IME, the one-level appeal requirement has been met and the provider is no longer able to appeal the same issue as a post-service appeal.

D. If the treating provider is not satisfied with the results of Prizm's Internal Appeals Process, the treating provider may file with the Dispute Resolution governed by regulations promulgated by the New Jersey Department of Banking and Insurance (N.J.A.C. 11:3-5) and can be initiated by contacting the Forthright at 732-271-6100 or toll-free at 1-888-881-6231. Information is also available on the Forthright website, http://www.nj-no-fault.com. AIG retains the right to file a Motion to remove any Superior Court action to the Personal Injury Protection Dispute Resolution Process pursuant to N.J.S.A. 39:6A-5.1. Unless emergent relief is sought, failure to utilize the Appeals Process prior to filing arbitration or litigation will invalidate an assignment of benefits

2. Assignment of Benefits – If the treating provider accepts assignment for payment of benefits please be aware that the treating provider is required to hold harmless the insured and the insurer for any reduction of benefits caused by the treating provider's failure to comply with the terms of Decision Point Review/Pre-Certification Plan. The appeals process as listed above must be followed by any treating provider who has accepted an assignment of benefits. The treating provider must agree to submit appeals for all issues (both those related to the medical decision as rendered during the Decision Point Review/ Precertification Process and to all others including but not limited to payment issues) through the Internal Appeals Process and exhaust such appeals process prior to submitting any unresolved disputes through the Forthright process. This appeal must be submitted to Prizm no later than 45 days prior to the initiation of any arbitration or litigation. Should the assignee choose to retain an attorney to handle the Appeals Process, they do so at their own expense. Prizm's written response to this appeal will be communicated to the requesting provider by fax or mail within 14 days of receipt of a pre-service appeal and within 30 days of receipt of a post-service appeal.

Please note that any provider that has accepted an assignment of benefits, must comply with and complete the Appeals Process as noted below prior to initiating arbitration or litigation. Completing the appeals process means timely submission of an appeal and receipt of the response prior to filing for alternate dispute resolution. Except for emergency care as defined in N.J.A.C. 11:3-4.2, any treatment that is the subject of the appeal that is performed prior to the receipt by the provider of the appeal decision shall invalidate the assignment of benefits.

Voluntary Network Services

Prizm has established a network of approved vendors for diagnostic imaging studies for all MRI's and Cat Scans, durable medical equipment with a cost or monthly rental over $100.00, prescription drugs and all electrodiagnostic testing, listed in N.J.A.C 11:3-4.5(b) 1-3, (unless performed in conjunction with a needle EMG H-Reflex and NCV studies by your treating provider). If you, the injured party utilize one of the pre-approved networks, the 30% co-payment will be waived. If any of the electro-diagnostic tests listed in N.J.A.C 11:3-4.5(b) are performed by the treating provider in conjunction with the needle EMG H-Reflex and NCV studies, the 30% co-payment will not apply. In cases of prescriptions, the $10.00 co-pay of *AIG* will be waived if obtained from one of the pre-approved networks.

When one of the services listed below is authorized through AIG ***Decision point review/Precertification*** process, detailed information about voluntary network providers will be supplied to the claimant or requesting provider as noted below. Those individuals who choose not to utilize the networks will be assessed an additional co-payment not to exceed 30% of the eligible charge. That co-payment will be the responsibility of the claimant.

Once an **MRI and/or Cat Scan** Diagnostic test that is subject to pre-approval through Decision Point Review/ Pre-Certification is authorized a representative of Prizm will contact the vendor and forward the information to them for scheduling purposes. A representative from the diagnostic facility will contact you, the injured party, and schedule the test at a time and place convenient to them.

Durable Medical Equipment with a cost or monthly rental over $100.00 is subject to Decision Point Review/Pre-Certification process and once the *Durable Medical Equipment* is authorized a representative of Prizm will contact the vendor and forward the

information to them for scheduling purposes. The equipment will be shipped to you; the injured party from the vendor, 24 hours after the request is received.

When you are in need of ***Prescription* Drugs** a pharmacy card will be issued that can be presented at numerous participating pharmacies. A list of participating pharmacies will be mailed to you once the need for a prescription has been identified.

Once an **Electro-diagnostic Test** subject to pre-approval through Decision Point Review/ Pre-Certification is authorized a representative of Prizm will contact the vendor and forward the information to them for scheduling purposes. A representative from the diagnostic facility will then contact you, the injured party, and schedule the test at a time and place convenient to them. When Electrodiagnostic tests are performed by your treating provider, in conjunction with a needle EMG, H-Reflex and NCV studies, the 30% co-payment will not apply.

Co-Payments

If an injured person uses a provider for a MRI, CT Scan or Electrodiagnostic testing from any of the above networks the 30% co-payment as per N.J.A.C 11:3-4.4(f) will not apply. However, if the treating provider performs the needle EMG, H-Reflex and NCV studies himself, this test and associated electrodiagnostics, the injured party would not receive a 30% co-payment.

In the case of prescription drugs when the injured party uses a provider from any of the above networks, the $10.00 co pay will not apply.

If the injured party goes outside of the network, the co-payments as stated above will apply.

Payments/ Reimbursement

AIG will reimburse all eligible medically necessary services in accordance with the most current New Jersey PIP Regulations and Fee Schedule relating to the date of service.

When provider fees aren't noted in a fee schedule, AIG will use the most current version of FAIR Health Data Base, consistent with the date of service, 75th percentile and with the providers' zip code, as proof of a usual, customary and reasonable fee.

For Pharmacy bills which aren't noted in a fee schedule, AIG will use the most current version of the Goldstandard with the geozip noted on the provider's address noted on the provider bill.

If the provider participates in an applicable PPO network, services may be reimbursed in accordance with the amount permitted under the PPO agreement.

AIG has no obligation to reimburse for specific CPT/HCPCS codes if they were approved (certified) in a Decision Point Review/Precertification request as it relates to applying payment methodology in the NJ PIP regulations, including but not limited to the NCCI edits. If the NCCI edits prohibit reimbursement for the codes that were billed such codes will not be reimbursed. The New Jersey Department of Banking and Insurance has adopted the NCCI edits to prevent duplication of services and unbundling of codes and the NCCI edits are part of the [Insert Carrier's name] insurer's obligation to only reimburse for medically necessary treatment. To obtain the entire current NCCI edits from the following web site: www.cms.gov/NationalCorrectCodInitEd/