



Horizon Casualty Services, Inc.



Horizon Casualty Services, Inc.

33 Washington Street
11th Floor
Newark, NJ 07102-3194
(866) 866-1427 – phone
(973) 622-7265 – fax
www.horizon-bcbsnj.com

February 27, 2005

Re: Patient:
SSN:
Date of Loss:
Claim Number:

Dear Provider:

We have been informed that the above named patient will be receiving treatment at your facility for injuries sustained in a motor vehicle accident. Horizon Casualty Services has been contracted by New Jersey Skylands Insurance (NJSI) to administer the Decision Point Review, Pre-Certification, and Voluntary Network processes on their behalf. Please read this entire letter carefully since it provides important information concerning how claims under NJSI's Personal Injury Protection coverage will be handled.

Pursuant to N.J.A.C. 11:3-4, you are required to notify us prior to performing certain diagnostic testing or treatment on this patient. The specific notification requirements are outlined in detail below and they apply to any such testing or treatment rendered on or after the tenth day following the motor vehicle accident. These requirements do not apply to emergency care.

Decision Point Review

Under N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance has published standard courses of treatment, known as Care Paths, for soft tissue injuries of the neck and back, collectively referred to as Identified Injuries (see Exhibit A) along with guidelines for the use of certain diagnostic tests.

The Care Paths provide that treatment be evaluated at certain intervals called Decision Points, which are represented by hexagonal boxes on the Care Paths. At these Decision Points, you must provide us with information about further treatment that you intend to provide so that we may perform a Decision Point Review. In addition, the administration of any test on the list provided in Exhibit B also requires a Decision Point Review regardless of the diagnosis.

Detailed information regarding the Care Paths and accompanying rules, are available on the internet on the New Jersey Department of Banking and Insurance web-site at www.nj.gov/dobi/aicrapg.htm or by calling Horizon Casualty Services, Inc. at (866) 866-1427.

Please be advised that failure to submit requests for decision point review, or failure to provide clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested will result in a 50% co-payment, even if the services are determined to be medically necessary and causally related to the motor vehicle accident. The co-payment applies between the time notification to the insurer was required and the time that proper notification is made and the insurer has an opportunity to respond.



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Mandatory Pre-Certification:

As described in N.J.A.C. 11:3-4.8, insurers may require pre-certification of certain treatments or diagnostic tests for diagnoses or treatments not included in the Care Paths. If your patient does not have an Identified Injury, you are required to obtain pre-certification of all services itemized in Exhibit C.

If you fail to submit requests for pre-certification, or fail to provide clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested, a 50% co-payment will apply, even if the services are determined to be medically necessary and causally related to the motor vehicle accident. The co-payment applies between the time notification to the insurer was required and the time that proper notification is made and the insurer has an opportunity to respond.

You are encouraged to maintain communication with Horizon Casualty Services, on a regular basis since pre-certification requirements may change.

Voluntary Pre-certification:

You are encouraged to participate in a voluntary pre-certification process by providing Horizon Casualty Services with a comprehensive treatment plan for both identified and other injuries. Horizon Casualty Services will utilize nationally accepted criteria and the Care Paths to work with you to certify a mutually agreeable course of treatment to include itemized services and a defined treatment period.

In consideration for your participation in the voluntary pre-certification process, the bills you submit, when consistent with the pre-certified services, will be paid without further review for medical necessity. In addition, having an approved treatment plan means that as long as treatment is consistent with the plan, additional notification to Horizon Casualty Services at decision points or for services included in the approved treatment plan that would otherwise be subject to pre-certification is not required. Additional services outside of the approved treatment plan that are subject to pre-certification must still be pre-certified. If you continue to participate in the voluntary pre-certification process for subsequent services, payment for pre-certified services will be made without further review for medical necessity.

How to submit Decision Point Review and Pre-certification Requests:

In order for us to properly evaluate the requested treatment or testing, we require that you provide us with all of the following information:

- Complete past medical history.
- Dates and description of previously rendered treatment.
- Diagnosis including ICD-9 codes and clinical symptoms.
- List of all diagnostic tests performed and their results.
- List of all pre-existing conditions.
- Prognosis.
- Description of recommended tests.
- Description of recommended treatment.

To facilitate your submission, we have enclosed a *Uniform Attending Provider Treatment Plan Form* as established by Department Order A04-143 that you may use. Please return this completed form, along with the information outlined above, to Horizon Casualty Services via Fax to 973-622-7265. Additional copies of this form are available on the NJ Department of Banking and Insurance website at <http://www.nj.gov/dobi/aicrapg.htm> or on the NJ Skylands website at www.njsi.com.



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Completing the Review Process:

Our review of your submission will be completed within 3 business days of receipt of the necessary information from you. Notice of our determination will be made to your office by telephone and confirmed in writing. If we fail to notify you within 3 business days, you may proceed with the testing or treatment until a final determination is communicated to you. In addition, if an independent physical or mental examination is required, treatment may proceed while the exam is being scheduled and until the results become available. Please keep in mind that any treatment rendered during this time is still subject to review for medical necessity.

Our review of your submission may result in one of the following outcomes:

- Requested service is certified.
- In the event we receive insufficient information to render an informed determination regarding the requested service, an administrative non-certification will be issued until we receive documentation sufficient to properly evaluate the request. If the documentation requested is not received within 15 days of the date of the administrative non-certification, the initial request will be forwarded to a Horizon Casualty Services medical director to review.
- In the event that we must amend the requested services (frequency, duration, intensity or place of service/treatment); your office will be notified by telephone with confirmation in writing. In addition, a Horizon Casualty Services medical director will be available to discuss the case with you should you desire.
- In the event that we are unable to render an informed determination based solely on the medical records, we may require the patient to attend an Independent Medical Examination (IME) to determine the necessity of continued treatment. If an IME is required, we may request that you provide additional medical records to the provider who will be conducting the examination. In accordance with N.J.A.C. 11:3-4.7(e), the requested records must be provided no later than the time of the examination. Please refer to Exhibit D for the IME requirements under N.J.A.C. 11:3-4.7(e). The results of the IME will be communicated to you within 3 business days of the examination. A copy of the examining physician's written report, if prepared, will be made available upon request.
- In the event we that are unable to certify a request from your office, you will be notified by telephone with confirmation in writing. Denials of treatment for decision point review or pre-certification requests on the basis of medical necessity must be determined by a physician, and in the case of treatment by a dentist, the denial must be by a dentist, in accordance with N.J.A.C. 11:3-4.7(c) 4. A Horizon Casualty Services medical director will be available to discuss the case with you. If the request is for a surgical procedure, we will assist the patient with scheduling a second surgical opinion, at the expense of New Jersey Skylands Insurance.

Please be aware that, pursuant to N.J.A.C. 11:3-4.4(d) and the NJSI policy, failure to submit requests for Decision Point Review or pre-certification or failure to submit clinically supported findings to support the treatment, diagnostic test or durable medical equipment will result in a 50% co-payment for any subject treatment or testing that is determined to be medically necessary and causally related to the motor vehicle accident. The co-payment applies between the time notification to the insurer was required and the time that proper notification is made and the insurer has an opportunity to respond.



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Reconsideration Process – 1st Level Appeal:

If we deny a request for Decision Point Review or Pre-Certification of any medical services or procedures under the NJSI policy, the clinical rationale for this determination will be made available at your request. You may contact us at (866) 866-1427 to request the clinical rationale.

Should you disagree with our determination concerning your request, you are entitled to seek a reconsideration of the decision from us within 30 days of the date of the denial letter. All requests for reconsideration should be submitted, in writing, to Horizon Casualty Services, 33 Washington Street, 11th Floor, Newark, NJ 07102-3194, Attention: PIP Services Dept., or you may fax your request to (973) 622-7265. All requests for reconsideration will be reviewed within three business days by A Horizon Casualty Services Medical Director, who will be available to consult with you during the reconsideration process. A final decision will be communicated to you in writing within 3 business days of Horizon's receipt your request for reconsideration and/or their receipt of any documentation they request from you in order to properly assess your application for reconsideration. Any dispute not resolved through the first level of appeal must be referred to the second level of appeal through NJSI as outlined in their Decision Point Review Plan.

Voluntary Network Services:

Please note that the NJSI policy includes a Voluntary Network Program for diagnostic testing, durable medical equipment (over \$50.00) and prescription drugs. If an Eligible Injured Person utilizes a conveniently located network provider for these services, the 30% out of network co-payment in the NJSI policy (\$10 for prescription drugs) will be waived. The voluntary network services may only be offered for and the co-payment may only apply to those tests specified in N.J.A.C. 11:3-4.8(b), which are listed in Exhibit E.

To locate a Voluntary Network provider in your area, simply contact HCS at 866-866-1427. Should you require any prescription drugs or durable medical equipment, please contact HCS at (866) 866-1427 for a participating network pharmacy or durable medical equipment supplier in your area. If you need additional information or assistance regarding the Voluntary Utilization program or the network providers, please contact Horizon Casualty Services at (866) 866-1427.

Assignment of Benefits and Dispute Resolution:

Any Eligible Injured Person (EIP) may assign their benefits to a "Health Care Provider" that is providing covered services or supplies in conjunction with the EIP's accident-related injuries. However, in order for any assignment of benefits to be valid, the provider must agree, in writing, to comply fully with the NJSI Decision Point Review/Pre-Certification plan and all the terms and conditions of the NJSI policy including, but not limited to, pre-certification/decision point reviews, exclusions, deductibles, co-payments, duties of cooperation, and dispute resolution requirements.

If you elect to accept an assignment from an EIP, you will be required to hold harmless the EIP, NJSI, and Horizon Casualty Services for any reduction of benefits caused by your failure to comply with the terms of the policy and/or the Decision Point Review / Pre-certification plan. You also agree that any disputed issues involving treatment or services provided to the EIP must be resolved through the dispute resolution process established by the NJSI policy and Decision Point Review / Pre-Certification plan. **The NJSI dispute resolution process requires that all assignees utilize the NJSI Internal Appeal process prior to filing any form of litigation with respect to PIP disputes.**

For details concerning the NJSI Internal Appeal process and its requirements, or if you would like to review the policy and your patient cannot provide you with a copy, please contact your NJSI Claim Representative for



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assistance. In addition, the Internal Appeals process is outlined in detail in the NJSI Decision Point Review / Pre-Certification Plan, which is available online at www.njsi.com for your reference.

Pre-certification of services by Horizon Casualty Services does not guarantee payment, which is subject to the patient's eligibility for benefits as well as the terms, conditions and exclusions of the NJSI policy. Coverage for a given claim is determined solely by NJSI.

The staff at Horizon Casualty Services is available to you and your patient, to answer questions and assist with the Decision Point Review / Pre-Certification process. Thank you for your cooperation.

Sincerely,

Horizon Casualty Services, Inc.
PIP Services Department

enclosures: Exhibit A – Identified Injuries
Exhibit B – Diagnostic tests subject to Decision Point Review
Exhibit C - Services that require Pre-certification
Uniform Attending Provider Treatment Plan Form
Exhibit D – IME requirements under N.J.A.C. 11: 3-4.7(e)
Exhibit E – List of applicable diagnostic tests
List of Voluntary Network Providers

cc: Claimant



Exhibit A – Identified Injuries

Cervical Spine: Soft Tissue Injury: 728.0 Disorders of muscle, ligament and fascia
728.85 Spasm of muscle
739.0 Non allopathic lesions – not elsewhere classified
739.1 Somatic dysfunction of cervical region
847.0 Sprains and strains of neck
847.9 Sprains and strains of back, unspecified site
922.3 Contusion of back
922.31 Contusion of back, excludes interscapular region
953.0 Injury to cervical root

Cervical Spine: Herniated Disc/Radiculopathy:
722.0 Displacement of cervical intervertebral disc without myelopathy
722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
722.70 Intervertebral disc disorder with myelopathy, unspecified region
722.71 Intervertebral disc disorder with myelopathy, cervical region
728.0 Disorders of muscle, ligament and fascia
739.0 Non allopathic lesions – not elsewhere classified
953.0 Injury to cervical root

Thoracic Spine: Soft Tissue Injury: 728.0 Disorders of muscle, ligament and fascia
728.85 Spasm of muscle
739.0 Non allopathic lesions – not elsewhere classified
739.2 Somatic dysfunction of thoracic region
739.8 Somatic dysfunction of rib cage
847.1 Sprains and strains, thoracic
847.9 Sprains and strains of back, unspecified site
922.3 Contusion of back
922.33 Contusion of back, interscapular region

Thoracic Spine: Herniated Disc/Radiculopathy:
722.0 Displacement of cervical intervertebral disc without myelopathy
722.1 Displacement of thoracic or lumbar intervertebral disc without myelopathy
722.11 Displacement of thoracic intervertebral disc without myelopathy
722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
722.70 Intervertebral disc disorder with myelopathy, unspecified region
722.72 Intervertebral disc disorder with myelopathy, thoracic region
728.0 Disorders of muscle, ligament and fascia
739.0 Non allopathic lesions – not elsewhere classified

Lumbar-Sacral Spine: Soft Tissue Injury:

- 728.0 Disorders of muscle, ligament and fascia
- 728.85 Spasm of muscle
- 739.0 Non allopathic lesions – not elsewhere classified
- 739.3 Somatic dysfunction of lumbar region
- 739.4 Somatic dysfunction of sacral region
- 846 Sprains and strains of sacroiliac region
- 846.0 Sprains and strains of lumbosacral (joint) (ligament)
- 846.1 Sprains and strains of sacroiliac ligament
- 846.2 Sprains and strains of sacrospinatus (ligament)
- 846.3 Sprains and strains of sacrotuberous (ligament)
- 846.8 Sprains and strains of other specified sites of sacroiliac region
- 846.9 Sprains and strains, unspecified site of sacroiliac region
- 847.2 Sprains and strains, lumbar
- 847.3 Sprains and strains, sacrum
- 847.4 Sprains and strains, coccyx
- 847.9 Sprains and strains, unspecified site of back
- 922.3 Contusion of back
- 922.31 Contusion of back, excludes interscapular region
- 953.2 Injury to lumbar root
- 953.3 Injury to sacral root

Lumbar-Sacral Spine: Herniated Disc/Radiculopathy:

- 722.1 Displacement of thoracic or lumbar intervertebral disc without myelopathy
- 722.10 Displacement of lumbar intervertebral disc without myelopathy
- 722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
- 722.70 Intervertebral disc disorder with myelopathy, unspecified region
- 722.73 Intervertebral disc disorder with myelopathy, lumbar region
- 728.0 Disorders of muscle, ligament and fascia
- 739.0 Non allopathic lesions – not elsewhere classified
- 953.3 Injury to sacral root

The following ICD-9-CM supplemental classification of external causes of injury may be used in addition to the specific diagnostic codes noted above and on each Care Path: E 810 through E 819, selected E 820 series codes. These codes may be used to indicate cause of injury as motor vehicle accident but should not be used without an associated diagnostic code.

Exhibit B – Diagnostic Tests Subject to Decision Point Review

- (1) Brain Audio Evoked Potential (BAEP);
- (2) Brain Evoked Potential (BEP);
- (3) Computer Assisted Tomographic studies (CT, CAT Scan)
- (4) Dynatron/Cyber Station/Cybex;
- (5) H-reflex Study;
- (6) Magnetic Resonance Imaging (MRI)
- (7) Needle EMG (EMG)
- (8) Nerve Conduction Velocity (NCV)
- (9) Somatosensory Evoked Potential (SSEP)
- (10) Sonogram / Ultrasound
- (11) Visual Evoked Potential / Visual Evoked Response (VEP/VER)
- (12) Any of the following “diagnostic tests” when not otherwise excluded from coverage under Exclusion C of the NJSI policy.
 - a. Brain Mapping;
 - b. Doppler Ultrasound;
 - c. Electroencephalogram (EEG);
 - d. Sonography;
 - e. Thermography / thermograms;
 - f. Videofluoroscopy
- (13) Any other “diagnostic test” that is subject to the requirements of our Decision Point Review / Pre-Certification Plan by New Jersey law or regulation.



Horizon Blue Cross Blue Shield of New Jersey



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Exhibit C – Services Requiring Pre-certification

1. Non-emergency in-patient and outpatient hospital care.
2. All non-emergency surgical procedures.
3. Durable medical equipment (including orthotics and prosthetics) costing greater than \$50, or rental greater than 30 days
4. Extended care rehabilitation facilities
5. Home health services.
6. Infusion therapy
7. Outpatient psychological/psychiatric services and testing.
8. All physical, occupational, speech, cognitive or other restorative therapy, or body part manipulation including Manipulation Under Anesthesia, except that provided for Identified Injuries in accordance with Decision Point Review
9. All pain management services, except that provided for Identified Injuries in accordance with Decision Point Review
10. All non-emergency diagnostic testing services, except those provided for Identified Injuries in accordance with Decision Point Review
11. Non-emergency dental restoration

Exhibit D – IME Requirements under N.J.A.C. 11:3-4.7(e)

The insurer shall notify the injured person or his or her designee that a physical examination is required to determine the medical necessity of further treatment, diagnostic testing or durable medical equipment. An insurer shall include reasonable procedures for the notification of the injured person and the treating medical provider where reimbursement of further treatment, diagnostic testing or durable medical equipment or testing will be denied for failure to appear at scheduled medical examinations.

- The appointment for the physical examination shall be scheduled within seven calendar days of receipt of the notice unless the injured person agrees to extend the time period.
- The medical examination shall be conducted by a provider in the same discipline as the treating provider.
- The medical examination shall be conducted at a location reasonably convenient to the injured person.
- The injured person, upon the request of the insurer, 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.
- The insurer shall notify the injured person, or his or her designee and the treating medical provider whether it will reimburse for further treatment, diagnostic tests or durable medical equipment as promptly as possible but in no case later than three business days after the examination.
- If the examining provider prepares a written report concerning the examination, the injured person or his or her designee shall be entitled to a copy upon request.

Insurers may include in their decision point review plan a procedure for the denial of reimbursement for treatment, diagnostic testing or durable medical equipment after repeated unexcused failure to attend a scheduled physical examination. The procedure shall provide for adequate notification of the insured and the treating provider of the consequences of failure to attend the examination.

Consequences of Unexcused Failure to Attend IMEs

The EIP (Eligible Injured Person) is expected to attend each examination as scheduled by us or our Plan Administrator.

Failure of an EIP to attend a scheduled examination without a minimum of 3 business days notice to the Plan Administrator shall constitute an **unexcused** failure to attend. The EIP must prove that proper notice was provided.

Failure of an EIP to attend a scheduled examination will be considered **excused** if the EIP notifies the Plan Administrator at least 3 business days prior to the examination date and re-schedules the appointment for a date, not to exceed 35 calendar days from the date of the original appointment.

If an EIP has an otherwise **excused** failure to attend a scheduled examination and does not re-schedule the appointment within 35 calendar days of the original appointment date, the failure to attend shall be deemed **unexcused**.

If an EIP re-schedules an examination for a date more than 35 calendar days from the date of the original appointment, any failure to attend the re-scheduled appointment will be **unexcused**.

If an EIP attends a scheduled examination, but fails to supply all requested medical records, test results, diagnostic imaging films and other pertinent materials; and proper photo identification it shall be deemed an **unexcused** failure to attend the examination and the examination will not take place.

If an EIP has more than one **unexcused** failure to attend a scheduled examination, notification will be sent to the EIP or his/her representative and all known treating providers advising that payment for all treatment, diagnostic testing, prescription drugs, and durable medical equipment provided on or after the date of notification and relating to the diagnosis code(s) and/or corresponding family of codes associated with the DPR/Pre-Certification request that necessitated scheduling of the examination will be denied.

In such cases, no future treatment, diagnostic testing, prescription drugs, or durable medical equipment associated with the relevant diagnosis code(s) will be reimbursable under our policy.

Exhibit E – List of Diagnostic Tests Applicable to Voluntary Network Services

- Magnetic Resonance Imaging (MRI)
- Computer Assisted Tomography (CT/CAT Scans)
- Needle Electromyography (needle EMG) *
- Somatosensory Evoked Potential (SSEP)**
- Visual Evoked Potential (VEP)**
- Brain Audio Evoked Potential (BAEP)**
- Brain Evoked Potential (BEP)**
- Nerve Conduction Velocity (VEP)**
- H-reflex Study**
- Electroencephalogram (EEG)**

* except when performed by the treating physician.

** except when performed by the treating physician in conjunction with a Needle EMG.