



United Services Automobile Association (USAA)

Decision Point Review Plan

And

Pre-certification Requirements

Decision Point Review

The New Jersey Department of Banking and Insurance has published standard courses of treatment, *Care Paths*, for soft tissue injuries of 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, either you or the treating health care provider must provide us with information about further treatment that is intended to be provided (this is referred to as *Decision Point Review*). Such information includes reasonable prior notice and the appropriate clinically supported findings that are being relied upon to support that the anticipated treatment, testing, durable medical equipment or prescription drugs is medically necessary. The *Decision Point Review* requirements do not apply to treatment or diagnostic tests administered during emergency care or during the first (10) days after the accident causing the injury. The Care Paths and accompanying rules and the Attending Provider Treatment Plan Form are available on the Internet on the Department's website at <http://www.state.nj.us/dobi/pipinfo/aicrapg.htm> or by calling Insight Services Group ("ISG"), USAA's PIP vendor which is a registered vendor pursuant to N.J.A.C. 11:3-4.7A, at 877-647-0012. The Initial Information Letter to Insured/Claimant/Providers is posted on USAA's website, <http://www.usaa.com> (scroll down to NJ Pre-cert Information).

In addition, the administration of certain diagnostic tests is subject to Decision Point Review regardless of the diagnosis. The following tests are subject to decision point review:

- Needle electromyography (needle EMG)
- Somatosensory evoked potential (SSEP), visual evoked potential (VEP), brain audio evoked potential (BAEP), brain evoked potential (BEP), nerve conduction velocity (NCV), and H-reflex studies
- Electroencephalogram (EEG)
- Videofluoroscopy
- Magnetic resonance imaging (MRI)
- Computer assisted tomographic studies (CT, CAT scan)
- Dynatron/cyber station/cybex
- Sonograms/ultrasound
- Thermography/ thermograms
- Brain mapping
- Any diagnostic test that is subject to the requirements of the Decision Point Review Plan by New Jersey law or regulation.

These diagnostic tests must be administered in accordance with DOBI regulations which set forth the requirements for the use of diagnostic tests in evaluation injuries sustained in an auto accident.

The following diagnostic tests are excluded from reimbursement:

- Spinal diagnostic ultrasound
- Iridology
- Reflexology
- Surrogate arm mentoring
- Brain mapping when not done in conjunction with appropriate neurodiagnostic testing
- Surface EMG
- Mandibular tracking and stimulation
- Any other diagnostic tests that NJ DOBI determines yield no data of any significant value in the development, evaluation and implementation of an appropriate plan of treatment for injuries sustained in motor vehicle accidents.

The following diagnostic tests are excluded for the diagnosis or treatment of TMJ/D:

- Mandibular tracking
- Surface EMG
- Sonography
- Doppler ultrasound
- Needle EMG
- Electroencephalogram (EEG)
- Thermograms/thermographs
- Video fluoroscopy
- Reflexology

Decision Point Review requests for all treatment must be either:

Faxed to (877) 395-7127

Or mail to:

Insight Services Group (ISG)
P.O. Box 5000
Daphne, AL 36526

Mandatory Pre-certification

New Jersey regulations provide that insurers may require pre-certification of certain treatments or diagnostic tests for other types of injuries or tests not included in the Care Paths. Pre-certification means providing us with notification of intended medical procedures, treatments, diagnostic tests, prescription supplies, durable medical equipment or other potentially covered medical expenses. Pre-certification requests include information related to all test results that have been completed, amount and type of treatment received to date, proposed diagnostic testing, date of accident, date of birth of the claimant, copy of legible treatment notes for last 60 calendar days, proposed CPT, CDT, HCPCS and procedural codes related to the proposed treatment. Pre-certification does not apply to treatment or diagnostic tests administered during emergency care or during the first ten (10) calendar days after the accident causing the injury.

The following are procedures, treatments, diagnostic tests, prescription supplies, durable medical equipment or other potentially covered medical expenses for which pre-certification is required:

- Non-emergency inpatient and outpatient hospital care; including the facility where the services will be rendered and any provider services associated with these services and/or care;
- Non-emergency surgical procedures; performed in a hospital, freestanding surgical center, hospital outpatient surgical facility, office, etc., and any provider services associated with the surgical procedure;
- Extended care rehabilitation facilities
- 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 Paths
- All physical, occupation, speech, vision, cognitive or other restorative therapy or other therapeutic or body-part manipulation including manipulation under anesthesia, except that provided for identified injuries in accordance with decision point review
- Non-Emergency Inpatient and Outpatient psychological/psychiatric services and testing including biofeedback
- All pain management services except as provided for identified injuries in accordance with decision point review
- Home health care
- Non-emergency dental restoration
- Acupuncture
- Infusion therapy
- Bone scans
- Vax-D DRX type devices
- Health club memberships
- Temporomandibular joint disorder (TMJ/D); any oral facial syndrome
- Transportation Services costing more than \$50.00
- Brain Mapping other than provided under Decision Point Review
- Durable Medical Equipment including orthotics and prosthetics costing more than \$50.00
- Prescriptions costing more than \$50.00
- Bio-analysis/drug screen testing
- Any procedure that uses an unspecified CPT; CDT; DSM IV; or HCPCS code
- CAT Scan with Myelogram and discogram;
- Current Perceptual Testing;
- Temperature gradient studies;
- Work hardening;
- Carpal tunnel syndrome;
- Podiatry services;
- Audiology services;
- Non-medical products, devices, services and activities and associated supplies not exclusively used for medical purposes or as durable medical goods with a monthly rental or rental in excess of thirty (30 days);

Pre-certification and Decision Point Review requests for all treatment must be either:

Faxed to (877) 395-7127 or
sent to:
Insight Services Group (ISG)
P.O. Box 5000
Daphne, AL 36526

ISG will review the Pre-certification request and supporting materials within three (3) business days of receipt. Business days are defined as Monday through Friday 9 AM to 5:30 PM Eastern Time excluding Federal or New Jersey State Holidays and any time when our offices are closed due to a declared state of emergency.

The Attending Provider Treatment Plan (AFTP) form may be completed by the treating health care provider and submitted to ISG for review, subject to the conditions and limitations set forth below. A treating health care provider is a person licensed or certified to perform health care treatment or services compensable as medical expenses in accordance with New Jersey laws and regulations. The following will apply to mandatory pre-certification: (1) Physical Therapists may submit AFTP forms with specific CPT codes to be used for treatment purposes; however, in order for this request to be considered complete, it must include the ordering physician's prescription, current and legible notes from the ordering physician indicating a need for physical therapy, which body part is to be treated and the response to previous treatment. A legible physical therapy evaluation must also be submitted; (2) Suppliers of Durable Medical Equipment (DME), transportation services, ambulatory surgical centers, and suppliers of prescription drugs may not submit AFTPs; and (3) Attending Provider Treatment Plans for diagnostic testing may only be submitted by the prescribing treating health care provider.

Our approval of a request for pre-certification will be based exclusively on medical necessity, as determined by using standards of good practice and standard professional treatment protocols, including, but not limited to, Care Paths recognized by the Commissioner of Banking and Insurance. Our final determination of the medical necessity of any disputed issues shall be made by a physician or dentist as appropriate for the injury and treatment contemplated.

The following diagnostic tests are excluded from reimbursement:

- Spinal diagnostic ultrasound
- Iridology
- Reflexology
- Surrogate arm mentoring
- Brain mapping when not done in conjunction with appropriate neurodiagnostic testing
- Surface EMG
- Mandibular tracking and stimulation
- Any other diagnostic tests that NJ DOBI determines yield no data of any significant value in the development, evaluation and implementation of an appropriate plan of treatment for injuries sustained in motor vehicle accidents.

The following diagnostic tests are excluded for the diagnosis or treatment of TMJ/D:

- Mandibular tracking
- Surface EMG
- Sonography
- Doppler ultrasound
- Needle EMG
- Electroencephalogram (EEG)
- Thermograms/thermographs
- Video fluoroscopy
- Reflexology

Voluntary Pre-certification

Health care providers are encouraged to participate in a voluntary pre-certification process by providing Insight Services Group (ISG) with a **comprehensive treatment plan** for both identified and other injuries.

ISG will utilize nationally accepted criteria and the Care Path to work with the health care provider to certify a mutually agreeable course of treatment to include itemized service and a defined treatment period. In consideration for the health care provider's participation in the voluntary certification process, the bills that are submitted, when consistent with the pre-certified services, will be paid so long as they are in accordance with the PIP medical fee schedule set forth in N.J.A.C. 11:3-29.4. (Note: N.J.A.C 11:3-29.6 is a balance billing provision). In addition, having an approved treatment plan means as long as treatment is consistent the plan, additional notification to ISG at decision points is not required.

DPR/Pre-certification Process

In order to submit a decision point review and precertification request, your medical provider must submit a legible completed attending provider treatment form via fax to 877-395-7127 or mail to ISG at the address listed above, along with legible clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested. A copy of the attending provider treatment form can be found on the internet on the New Jersey Department of Banking and Insurance website at www.nj.gov/dobi/aicrapg.htm or by calling Insight Services Group (ISG), USAA's PIP vendor which is a registered vendor pursuant to N.J.A.C. 11:3-4.7A, at 877-647-0012.

We will notify you or your treating health care provider of our decision to authorize or deny reimbursement of the anticipated treatment, testing durable medical equipment or prescription drugs as promptly as possible, but no later than three (3) business days after a request has been received. Business days are defined as Monday through Friday 9 AM to 5:30 PM Eastern Time excluding Federal or New Jersey State Holidays and any time when our offices are closed due to a declared state of emergency. A request for treatment, testing, durable medical equipment or prescription drugs is to be submitted together with legible, conspicuously presented, clinically supported findings that the proposed treatment, testing, durable medical equipment or prescription drugs is in accordance with the standards of medical necessity established under USAA's policy and New Jersey law. Any denial of reimbursement for further medical treatment or tests, durable medical equipment or prescription drugs will be based on the determination of a physician or dentist. If we fail to take any action or fail to respond within three (3) business days after receiving the required notification and supporting medical documentation at a decision point, or for pre-certification, then the treating health care provider is permitted to continue the course of treatment until we provide

the required notice. Please note that the decision point review and pre-certification requirements do not apply to treatment or diagnostic tests administered during emergency care or during the first ten (10) calendar days after the accident causing the injury.

Penalty/Co-Payments

If requests for pre-certification or decision point reviews pursuant to N.J.A.C. 11:3-4.4(e) for anticipated treatment, testing, durable medical equipment or prescription drugs are not submitted or clinically supported findings that support the request are not supplied, payment of your bills will be subject to a penalty co-payment of 50 percent (50%) even if the services are determined to be medically necessary. This co-payment is in addition to any deductible required under the Personal Injury Protection coverage.

For purposes of co-payments and deductibles, the order of application will be applied consistently in the following manner:

1. Penalty co-payment (if applicable)
2. Insured deductible
3. Insured co-payment

In addition, any approved treatment, testing or DME performed/supplied after the authorization period expires would be considered unauthorized and subject to a penalty co-payment of 50% even if the services are determined to be medically necessary.

Voluntary Networks

ISG has established networks of pre-approved vendors which can be recommended designated providers for diagnostic tests: MRI, CT, CAT Scan, Somatosensory evoked potential (SSEP), visual evoked potential (VEP), brain audio evoked potential (BAEP), brain evoked potential (BEP), nerve conduction velocity (NCV), and H-reflex study, Electroencephalogram (EEG), needle electromyography (needle EMG) and durable medical equipment and prescriptions costing more than \$50.00. An exception from the network requirement applies for any of the electro diagnostic tests performed in N.J.A.C. 11:3-4.5(b) 1-3 when done in conjunction with a needle EMG performed by the treating provider. The designated providers are approved through a Workers Compensation Managed Care Organization.

You are encouraged, but not required, to obtain the noted service from one of the pre-approved vendors. If you use a pre-approved vendor from one of these networks for medically necessary goods or services, you will be fully reimbursed for those goods and services consistent with the terms of your auto insurance policy. If you choose to use a vendor that is not part of these pre-approved networks, we will provide reimbursement for medically necessary goods and services but only up to eightieth percentile (80%) of the lesser of the following: (1) the charge or fee provided for in N.J.A.C. 11:3-29, or (2) the vendor's application of an approved usual, customary and reasonable charge database, or (3) charge amount. The Networks can be accessed either through a referral from the Nurse Case manager or by contacting

- Carisk Imaging - Diagnostic testing 888-340-5850
- Optum - Durable Medical Equipment and Prescriptions 800-777-3574

ISG has PPO Networks available that include providers in all specialties, hospitals, outpatient facilities, and urgent care centers throughout New Jersey and are approved through a Workers Compensation Managed Care Organization as permitted under N.J.A.C. 11:3-4.8(a). The Nurse Case Manager can provide a current PPO network list. The use of these networks is strictly voluntary and the choice of health care provider is always made by the injured party. The PPO networks are provided as a service to those persons who do not have a preferred health care provider by giving them recommendations of providers that they may select from.

Internal Appeals Process

USAA requires that two (2) types of internal appeals be made. The first is a "pre-service appeal" which relates to the medical necessity of future treatment or testing that was requested by the medical provider on a properly completed decision point review/pre-certification request. The second is an "post-service appeal" which is an appeal of all other types of adverse decisions. Each issue shall only be required to receive one internal appeal review by us prior to making a demand for alternative dispute resolution in accordance with N.J.A.C. 11:3-5.

Pre-Service Appeal

A pre-service appeal is an appeal of decision point review and/or precertification denials or modification prior to performance or issuance of the requested medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment and prescriptions. In order to be considered a valid pre- service appeal all the requirements listed below must be met:

1. ISG must be notified within thirty (30) calendar days after the provider's receipt of the written denial or modification of requested services.
2. An appeal must be communicated to the Nurse Case Manager in writing with supporting documentation and reasons for the appeal. Submission of information identical to the initial documentation submitted in support of the initial request shall not be accepted as an appeal request.
3. The appeal must be submitted on the State Mandated Pre-Service Appeal Form and all the required fields as designated by an asterisk (*) must be completed in order to be considered. If either the State Mandated Pre-Service Appeal Form is not submitted or required fields on the State Mandated Pre-Service Appeal Form are not completed, the Appeal will be administratively denied. In addition, applicable fields 29-34 on the State Mandated Pre-Service Appeal Form must be completed and if any of these fields is not completed, the Appeal may be administratively denied.
4. Appeals must be submitted to ISG. either via fax, or via mail at the address designated below:
Faxed to (877) 395-7127
or
Mailed to: Insight Services Group (ISG)
P.O. Box 5000
Daphne, AL 36526
5. Only those providers who have a valid Assignment of Benefits are permitted to file an appeal. Providers who are assigned benefits or who have a valid Proof of Assignment from the insured must make and complete an internal appeal prior to making a request for dispute resolution.
6. Filing an appeal as stated in subsections 1-5 above is a condition precedent to filing through Alternative Dispute Resolution.
7. Available required information about a dispute should be submitted as part of the internal appeals process. Only with a showing of substantial good cause should additional required information not submitted as part of the internal appeal process be submitted in arbitration for the first time.

A decision shall be issued by the insurer to the provider who submitted the Pre-Service Appeal no later than fourteen (14) days after receipt of the State Mandated Pre-Service Appeal Form and any supporting documentation.

Post-Service Appeal

A Post-Service Appeal is an appeal made subsequent to the performance or issuance of the services. In order to be considered a valid post-service appeal, all the requirements listed below must be met:

1. ISG must be notified of a post service appeal at least 45 days prior to initiating Alternative Dispute Resolution or filing an action in Superior Court.
2. An appeal must be communicated in writing with supporting documentation and reasons for the appeal. Submission of information identical to the initial documentation submitted in support of the billed services shall not be accepted as an appeal request.
3. The appeal must be submitted on the State Mandated Post-Service Appeal Form and the required fields as designated by an asterisk (*) be completed. If either the State Mandated Post-Service Appeal Form is not submitted or required fields are not completed, the Appeal will be administratively denied. In addition, applicable fields 29-38 inclusive on the State Mandated Post-Service Appeal Form must be completed and if any of these fields is not completed, the Appeal may be administratively denied.
4. Appeals must be submitted to ISG either via fax, or via mail at the address

below:Faxed to (877) 395-7127

Or

Mailed to: Insight Services Group (ISG)

P.O. Box 5000

Daphne, AL 36526

5. Only those providers who have a valid Assignment of Benefits are permitted to file an appeal. Providers who are assigned benefits or who have a valid Proof of Assignment from the insured/ eligible injured party must make and complete an internal appeal prior to make a request for dispute resolution.
6. Filing an appeal as stated in subsections 1-5 above is a condition precedent to filing through Alternative Dispute Resolution.
7. Available required information about a dispute should be submitted as part of the internal appeal process. Only with a showing of substantial good cause should additional required information not submitted as part of the internal appeals process be submitted in arbitration for the first time.

Medical necessity appeals of denial of Decision Point Review or Precertification requests cannot be made as a Post-Service Appeal.

A decision shall be issued by the insurer to the provider who submitted the Post-Service appeal no later than thirty (30) days after receipt of the State Mandated Post Service Appeal Form and any supporting documentation.

Any new issue raised post-service shall be submitted to the internal appeals process before initiating alternative dispute resolution. Proof of a timely-filed appeal is required documentation when an Alternate Dispute Resolution demand is made.

Assignment of Benefits

USAA may at its option accept the Insured's assignment of payment of medical expenses to a health care provider, if it is provided in accordance with an assignment of payment form approved by us. A copy of USAA's form is included in the PIP package provided to the Insured. Assignment of an insured's rights to receive benefits for medically necessary treatment, durable medical equipment tests or other services is prohibited except to a licensed health care provider who agrees:

- (1) to comply with all requirements of our decision point review plan for making decision point review and pre-certification requests,
- (2) to initiate all pre-certification review and decision point review requests as required by our plan;
- (3) to submit disputes in accordance with the Internal Appeal procedures in the Plan and to exhaust all internal appeals prior to initiating a demand for dispute resolution;
- (4) Completes the internal appeals process, which shall be a condition precedent to the filing of a demand for alternative dispute resolution for any issue related to bill payment, bill processing, Decision Point Review Request or Precertification request. Completion of the internal appeal 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;
- (5) To hold the Insured harmless for penalty co-payments imposed by USAA based on the healthcare provider's failure to follow the requirements of our decision point review or pre-certification plan;
- (6) Submit to statements or examinations under oath as often as deemed reasonable and necessary

If USAA has not given its written consent to an assignment of the rights and duties of the Insured under the USAA Personal Injury Protection benefits coverage, USAA will pay the PIP benefits to the Insured or to the person or organization furnishing the products or services for which such benefits are due. These benefits are not assignable except to providers of service.

Medical Examinations

At our request, we may require an independent medical examination (IME) to determine medical necessity of further treatment or testing. The scheduling of the appointment date will be done within seven (7) calendar days of receipt of the notice that an IME is required unless the injured person agrees to extend the time period. The IME will be completed by a provider in the same discipline as the treating provider and upon request the injured person must provide medical records and other pertinent information to the provider conducting the IME. The IME will be conducted at a location reasonably convenient to the insured. Within three (3) business days following the examination the injured party and provider will be notified as to whether they will be reimbursed for further treatment. The injured party or his designee may request a copy of a written report prepared in conjunction with any physical examination we request. If there are two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to the Insured, attorney if noted, and all health care providers providing treatment for the diagnosis (and related diagnosis) contained in the attending physician's treatment plan form. The notification will place the parties on notice that all future treatment, diagnostic testing, durable medical equipment, vision restorative therapy, health club memberships, or prescription drugs 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. Except for surgery, procedures performed in ambulatory surgical centers and invasive dental procedures, treatment may proceed while the IME is being scheduled and until the results become available. However only medically necessary treatment related to the motor vehicle accident will be reimbursed.

Sincerely,

Nurse Case Manager Name
Telephone: 877-647-0012, ext
Fax: (877) 395-7127

Cc: