



Travelers Decision Point Review/Precertification Plan

Plan Summary

Travelers Decision Point Review/Precertification Plan (“Plan”) is compliant with relevant New Jersey statutes and regulations and is offered as a component of private passenger automobile insurance policies with Personal Injury Protection (“PIP”) and emergency personal injury. This Plan applies to all participating Travelers companies.

The Plan manages utilization of medically necessary treatment rendered to an eligible injured person in connection with an injury covered by a Travelers automobile insurance policy. Utilization management under the Plan is in accordance with New Jersey Department of Banking and Insurance (“NJDOBI”) regulations governing Identified Injuries and related Care Paths, Decision Point Reviews, and Precertification.

Identified Injuries are those that the NJDOBI has determined to be suitable for medical treatment protocols. These treatment protocols, Care Paths, are standard courses of treatment for soft tissue injuries and injuries of the neck and back. Evaluation points within a Care Path are referred to as Decision Points. At such Decision Points providers must supply the insurer with information regarding intended treatment including clinically supported findings regarding such treatment. Following receipt of complete information from a provider, an insurer must make a determination about the continuation of, or choice of, further treatment for an Identified Injury and whether or not to perform one of the diagnostic tests listed in N.J.A.C. 11:3-4.5(b) for both Identified Injuries and all other injuries. Travelers uses standard professional treatment protocols when making medical necessity determinations. Any determination to disapprove treatment will be the made by a physician, and in the case of treatment prescribed by a dentist, a dentist will make the determination.

In addition to Identified Injuries, some other treatments and services under the Plan require Precertification prior to administration. Those treatments not subject to Decision Point Review but that require Precertification under the Plan before being administered are listed below.

Plan Notification

Travelers will advise the named insured of the Plan’s Care Path and Precertification requirements upon policy issuance and renewal and similarly advise all claimants seeking PIP Coverage upon presentation of a claim. The notification will include instructions on how to comply with Plan requirements.

Emergency care or any medically necessary treatment provided during the 10 days immediately following the accident is not subject to Decision Point Review or Precertification; however only treatment that is medically necessary and related to the claim will be reimbursed.

Review Overview

Travelers will perform Decision Point Reviews as required by the NJDOBI Care Paths for Identified Injuries using standards of good practice and standard professional treatment protocols. Medical necessity determinations will be based upon the clinical information provided by the provider or claimant. All requests for treatment review, and any information supporting the medical necessity of the treatment or services, must be sent to Travelers for review on the Attending Provider Treatment Form prior to any treatment being rendered and in a reasonable time to allow for review in order to obtain PIP Coverage. Requests that do not include the necessary information will be administratively denied as deficient until the required information is provided. A provider may submit a Comprehensive Treatment Plan for approval, and if approved,



that provider has to seek further approval only for those treatments or services not encompassed on the Attending Provider Treatment Form.

All requests for surgical procedures (CPT codes 10000-69999) require supplemental information including the name of the facility where services will be performed, the proposed surgery date, the need for and names of co-surgeons, assistant surgeons, physician assistants and/or registered nurse first assistants as supported by the Centers for Medicare and Medicaid Services ("CMS") guidelines, anticipated post-operative services and care not included in the global fee period, including but not limited to, therapy, diagnostic testing and/or DME. This information must be submitted on or with the Surgery Precertification Request for NJ PIP Claims Form. Requests for surgeries that do not include the necessary information will be administratively denied as deficient until the required information is provided.

Decision Point Review/Precertification requests must be faxed to (866) 296-4180. Requests sent by any other means or to any other facsimile number will not be considered.

Precertification reviews will be required of any claimant seeking PIP Coverage for:

1. Non-emergency inpatient or outpatient hospital care;
2. Non-emergency surgery performed at a hospital, outpatient surgical center, provider's office, etc.
3. Physical, occupational, speech, cognitive or other restorative therapy or body part manipulation treatment, including manipulation under anesthesia, except for that treatment for Identified Injuries in accordance with Decision Point Review;
4. All outpatient psychological/psychiatric testing and/or services;
5. All pain management services except as provided for Identified Injuries in accordance with Decision Point Review, including but not limited to:
 - i. Acupuncture;
 - ii. Nerve blocks,
 - iii. Manipulations under anesthesia;
 - iv. Epidural steroid injections;
 - v. Biofeedback;
 - vi. Trigger point injections;
 - vii. Anesthesia when performed in conjunction with invasive techniques
 - viii. Radio frequency/rhyzotomy
 - ix. Implantation of spinal stimulators or spinal pumps
 - x. TENS units (transcutaneous electrical nerve stimulation)
 - xi. PENS units (percutaneous electrical nerve stimulation); and
 - xii. Electro-acupuncture devices;
6. Treatment for carpal tunnel syndrome;
7. Treatment testing and/or DME relating to temporomandibular disorders and oral facial syndrome;
8. Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of \$50;
9. Non-emergency dental restoration;
10. Any procedure that uses an unspecified CPT; CDT; DSM IV; HCPCS codes;
11. Home health care;
12. Extended rehabilitation facilities;
13. Bone scans;
14. Prescriptions, including but not limited to, Schedule II, III and IV Controlled Substances, as defined by the Drug Enforcement Administration when prescribed for more than three (3) times in a row, for a time period of more than ninety (90) days, or more than three (3) times in one (1) year or in excess of \$50 for a single fill and/or a thirty (30) day supply;
15. Infusion therapy;
16. Vax-D/DRX type devices;
17. Transportation Services in excess of \$50;

18. Brain Mapping other than provided under Decision Point Review;
19. Podiatry;
20. Audiology;
21. Computerized muscle testing;
22. Work hardening;
23. Current perceptual testing;
24. Temperature gradient studies;
25. Interoperative neuromonitoring;
26. Videonystagmography (“VNG”), nystagmus, vestibular, balance or cognitive testing;
27. CAT/myelogram; or
28. Discogram.

Reviews will be completed within 3 business days from receipt of the request for review and sufficient clinically supported findings justifying the treatment. Review time is calculated beginning on the day following the date of receipt and ends at the close of business on the third business day following the start of the review. Regular business hours are Monday through Friday 8:00 AM to 5:00 PM, EST/EDT. A business day does not include Saturdays, Sundays, legal holidays or days that the office is closed due to severe weather, mandatory evacuation or a State of Emergency.

Reviews may result in the following actions:

- Authorization of the requested treatments or services;
- Modification or partial approval of the requested treatments or services where the information submitted is incomplete and/or fails to provide clinically supported findings to establish medical necessity;
- Request for additional documentation from the attending providers when the submitted documentation is illegible;
- Notification that the request for review cannot be processed because it is incomplete due to the lack of, or an incomplete, Attending Provider Treatment Form and/or Surgery Precertification Request for NJ PIP Claims Form. An Attending Provider Treatment Form and Surgery Precertification Request for NJ PIP Claims Form will be considered to be incomplete if it lacks information that is vital to determine medical necessity, is not signed by the treating provider of the proper specialty, and/or is undated;
- Schedule a physical examination of the claimant because the request for review did not provide sufficient medical documentation necessary to make a determination; or
- Denial of the requested treatments or services. Denials are issued when medical necessity is not established; this includes when insufficient medical documentation submitted.

Pursuant to N.J.A.C. 11:3-4.5, the following tests are prohibited under any circumstances:

- Spinal diagnostic ultrasound
- Iridology
- Reflexology
- Surrogate arm mentoring
- Surface electromyography (surface EMG)
- Mandibular tracking and stimulation
- X-ray digitization and/or computer assisted radiographic mensuration
- Any other diagnostic test that is determined by New Jersey law or regulation to be ineligible for personal injury protection coverage.



Pursuant to N.J.A.C. 11:3-4.5(f) and 13:30-8.22(b), Travelers will 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 temporomandibular joint disorder (TMJ/D):

- Mandibular tracking
- Surface EMG
- Sonography
- Doppler ultrasound
- Needle EMG
- Electroencephalogram (“EEG”)
- Thermograms/thermographs
- Videofluoroscopy
- Reflexology

Travelers will also not provide reimbursement for the following:

- Laboratory testing services from any entity that is not certified by the Department of Health and Human Services (“HHS”).
- Prescription medications, drugs and biologicals that are not approved by the United States Food and Drug Administration (“USFDA”).
- Compound prescription medications, drugs and/or biologicals that, as compounded, are not approved by the USFDA, including but not limited to, compounds that may have in their formulary one or more medications, drugs and/or biologicals individually approved by the USFDA.
- Travelers has no obligation to reimburse for specific CPT/HCPC codes, even if those codes are pre-certified through a Decision Point Review or Precertification request as being medically necessary and causally related to the accident, if the NJDOBI has adopted payment adjudication methodologies in the NJ PIP regulations that consider those charges not to be reimbursable. These payment adjudication methodologies include, but are not limited to, the NCCI edits and other Medicare guidelines. The DOBI’s interpretation of the auto medical fee schedule can be viewed at www.state.nj.us/dobi/pipinfo/medfeequa.htm. The current NCCI edits can be obtained from the Center for Medicare and Medicaid Services website: <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html>.

Independent Medical Examinations

An independent medical examination is a physical examination of the claimant. If such an exam is requested:

1. The exam will be scheduled within seven (7) calendar days of the provision of the determination notice to the claimant stating that a physical exam will be required to determine medical necessity of a proposed treatment or services, unless the claimant agrees to an extension of time. Calendar days are calculated beginning on the date following the day of the request and end the appropriate number of days later at 5:00 PM, EST/EDT. However, if the last day of the review calculation falls on a Saturday, Sunday or legal holiday, the last day of review is deemed to be the following weekday or non-legal holiday day.
2. Notice of the date, time and location of the exam will be provided to the claimant, and claimant’s designee, if noted. The notice of the examination will include details of the consequences for more than one unexcused failure to attend. If the examination is missed, a notice will be sent with a rescheduled appointment. Upon the second failure to

- attend an exam, notification will immediately be sent to the claimant, his/her designee, and/or any treating providers for the requested or related treatments contained in the Attending Provider Treatment Plan form stating that all future treatment, diagnostic testing, durable medical equipment or prescription drugs required for the treatment, diagnosis or related diagnosis contained in the Attending Provider Treatment Plan form, will not be reimbursable due to failure to comply with the Plan .
3. It will be conducted by a provider in the same discipline as the treating provider.
 4. It will be conducted at a location reasonably convenient to the claimant.
 5. The claimant must bring valid government issued photo identification (for example, driver's license, passport, U.S. military ID, or permanent resident card) to the exam.
 6. If the claimant is non-English speaking, an interpreter of legal age must accompany the claimant to the exam. Travelers will not provide an interpreter or reimburse for this expense.
 7. The claimant must provide copies of all medical records, diagnostic studies (films/digital images and reports), and other pertinent information related to the claimant's injuries to the provider conducting the exam prior to or at the time of the exam.
 8. Claimant must fully cooperate with the provider conducting the exam and may be asked to bring specific prescribed DME items to the exam.

The following will result in an unexcused failure to attend the IME:

1. Failure to present valid government issued photo identification (for example, driver's license, passport, U.S. military ID, or permanent resident card) to the provider conducting the exam at the time of the exam.
2. Failure to be accompanied by an interpreter of legal age if the claimant is non-English speaking. Travelers will not pay for any interpreter fees and/or costs.
3. Failure to attend any of the scheduled exam appointments for any unexcused reason.
4. Failure to provide to the provider conducting the exam with medical records, diagnostic studies (films/digital images and reports), and other pertinent information related to the claimant's injuries before or at the time of the scheduled exam.
5. Failure to obtain approval from Travelers to reschedule the exam. Approval must be requested at least three (3) full business days prior to the originally scheduled appointment. Approval shall be at the sole discretion of Travelers.

Treatment, except for non-emergent tests, surgery, procedures performed in ambulatory surgical centers, outpatient facilities and/or hospitals and invasive dental procedures, may proceed while the exam is being scheduled and until the results become available. However, only medically necessary treatment will be reimbursable pursuant to the policy of insurance. The claimant will be notified of a determination as soon as possible but no later than three (3) business days following the exam. Notification of the determination will be sent to the claimant, his/her designee, if applicable, and/or the treating provider. Copies of any written reports prepared in conjunction with the exam will be provided to the claimant or his/her designee upon written request.

Voluntary Networks

In accordance with N.J.A.C. 11:3-4.8, the Plan includes voluntary networks for:

1. Magnetic Resonance Imaging (MRI)
2. Computer Assisted Tomography (CT/CAT Scans)
3. Needle Electromyography (needle EMG), H-reflex and nerve conduction velocity (NCV) tests, except when performed together by the treating physician.
4. Somatosensory Evoked Potential (SSEP)
5. Visual Evoked Potential (VEP)
6. Brain Audio Evoked Potential (BAEP)
7. Brain Evoked Potential (BEP)

8. Nerve Conduction Velocity (NCV)
9. H reflex Study
10. Electroencephalogram (EEG)
11. Durable Medical Equipment with a cost or monthly rental in excess of \$50
12. Services, equipment or accommodations provided by an ambulatory surgery facility.

If a claimant or provider does not use a network provider to obtain the above specified goods and/or services, they will be assessed a co-payment of thirty percent (30%) of the eligible charges.

Claimants and providers are sent information on how to access a list of the network providers:

1. Once Travelers receives a Decision Point Review or Precertification request for one of the above specified goods and/or services, and
2. When either the Plan or the Precertification process results in the authorization of one of the above specified goods and/or services

For available network provider information, the claimant and/or provider may call:


For Diagnostic Imaging Horizon Casualty Services, Inc. provides access to the following in-network diagnostic centers:

- a. One Call Care Management at (800) 872-2875.
- b. If a One Call Care Management diagnostic center is not located near the eligible injured person, Horizon Casualty Services, Inc. can provide assistance at (888) 776-8280.

For Electrodiagnostic Testing, Durable Medical Equipment, and/or Services, equipment or accommodations provided by an ambulatory surgery facility:

- a. Horizon Casualty Services, Inc. at (888) 776-8280.

Claimants and providers can also find in-network providers on the website:

<https://www.travelers.com/claims/claim-services.aspx>. On the website, Vendors in Travelers' Voluntary Utilization Networks are designated with a  next to their name.

As required by NJAC 11:3-4.8(d)4, the voluntary networks that are part of the Travelers plan are approved as part of a workers' compensation managed care organization.

Penalties for Non-Compliance

Failure to report a claim or to provide any requested claim information to Travelers as promptly as possible following an accident will result in the following co-payment penalties:

- 25% co-payment penalty for notice that is provided 30 – 59 days after the loss; and
- 50% co-payment penalty for notice that is provided 60 or more days after the loss.

Failure to request a Decision Point Review or Precertification where required or failure to provide clinically supported findings that support the treatment, diagnostic test, or durable medical equipment requested shall result in a co-payment of 50 percent (50%) of the eligible charge. This penalty applies to medically necessary diagnostic tests, treatments or durable medical goods that were provided between the time notification to Travelers was required and the time proper notification was made and Travelers had a reasonable opportunity to respond (3 business days) in accordance with its approved Decision Point Review Plan.



Internal Appeal Procedure

As a condition precedent to filing arbitration or litigation, a provider who has accepted an assignment, or any claimant, must submit a written request to appeal any and all disputes. This includes but is not limited to claims for unpaid medical bills for medical expenses and for unpaid goods and/or services not authorized and/or denied in the Decision Point Review and Precertification processes.

All appeals must be submitted using the forms established by the NJDOBI in accordance with NJAC 11:3-4.7B(d) and posted on the NJDOBI's website. All forms must be fully completed, including the claim number, date of loss, claimant name and clearly identify the adverse decision(s)/contested issue(s) that is(are) the basis for the appeal. Treatment appeals must specifically explain the reason the treatment request should be reconsidered and, if applicable, provide supporting medical/dental documentation and/or test results that were not submitted with the original request for treatment. It is not necessary to resubmit documentation previously submitted. Requests that do not include the necessary information will be administratively denied as deficient until the required information is provided.

Internal appeal requests must be faxed to (866) 296-4180. Requests sent by any other means or to any other facsimile number will not be considered.

Pursuant to NJAC 11:3-4.7B, only one-level of appeal is required for each appealed issue before initiating the Dispute Resolution process or filing an action in Superior Court. The following are the two (2) types of internal appeals:

1. **Pre-Service** – Appeals of Decision Point Review and/or Precertification 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”). These appeals must be made no later than 30 days after receipt of a written denial or modification of requested services. Submission of documentation/information identical to the initial material submitted in support of the original request will not be accepted as a request for appeal. Provided that additional necessary medical documentation/information has been submitted, a response to the appeal request shall be made within 14 days after receipt of the pre-service appeal form and any supporting documentation. If it is determined that peer review or an Independent Medical Examination is appropriate, this information will be communicated within 14 days as well.
2. **Post-Service** – Appeals subsequent to the performance or issuance of the services, including but not limited to, bill disputes, Decision Point Review/Precertification penalties and coding discrepancies. These appeals must be submitted at least 45 days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or filing an action in Superior Court. Submission of documentation/information identical to the original material submitted will not be accepted as a request for appeal. Provided that additional documentation/information has been submitted, a response shall be issued by the insurer to the provider who submitted the appeal no later than 30 days after receipt of the appeal form and any supporting documentation.

If a claimant or provider retains counsel to represent them during the Internal Appeal Procedure, they do so strictly at their own expense. No reimbursement will be issued for counsel fees or any other costs, regardless of the outcome of the appeal.



Dispute Resolution

Disputes that have not been resolved via the Internal Appeal Procedure may be submitted through the Personal Injury Protection Dispute Resolution process governed by N.J.A.C. 11:3-5. As of the filing of this plan, the NJDOBI has assigned Forthright as the administrator of the Personal Injury Protection Dispute Resolution process. If the NJDOBI changes the administrator, information about the new administrator will be available on the NJDOBI website and this Plan shall remain in full force and effect. The process can be initiated by contacting Forthright at (732) 271-6100 or toll-free at (888) 881-6231. Information is also available on Forthright's website, www.nj-nofault.com. Travelers retains the right to file a Motion to remove any Superior Court action to the Personal Injury Protection Dispute Resolution process.

Unless the dispute involves a request for emergent relief, failure to utilize the Internal Appeal Procedure prior to initiating litigation or the Personal Injury Protection Dispute Process will invalidate an assignment of benefits.

Assignment of Benefits

Benefits under the Plan will not be assignable except to providers of service for a covered claim. Payments will be made directly to a provider *only* if the provider completes the Conditional Assignment of Benefits form. As a condition of Assignment of Benefits, the medical provider must agree to the following:

- Comply with all of the requirements of the Plan and terms and conditions of the Travelers policy;
- Comply with all requests from Travelers for additional information concerning the presentation of the claim including but not limited to the submission of medical records that include clinically supported findings for the diagnosis, causal relationship to the accident, Care Plan and, if necessary, submit to Examinations Under Oath;
- Submit all disputes in accordance with the Plan's Internal Appeal Procedure. Only after final determination of the Internal Appeal Procedure will the medical provider institute litigation or initiate the Personal Injury Protection Dispute Resolution Process and hold Travelers harmless with regard to legal fees and costs incurred for failure to comply with the Internal Appeal Procedure; and
- Hold harmless the claimant for any co-payment penalty or reduction of payment for services caused by the provider's failure to comply with the terms of the Plan, insofar as the medical provider will not seek reimbursement for such penalty from the claimant for any unpaid portion of the bill attributable to such failure to comply with this Plan.