

## IMPORTANT NOTICE

### INTRODUCTION

At GEICO, we understand that when you purchase an automobile insurance policy, you are buying protection and peace of mind in the event you are injured in an accident. It is, therefore, important to you that GEICO provide you first rate claims service. Our goal is to process claims for medically necessary treatment and testing quickly and fairly.

This document explains how your medical claims will be handled, including the Decision Point Review/Pre-certification requirements which you and your medical provider must follow in order to receive the maximum benefits provided by your policy. Please read this document carefully.

If you (or anyone else making a claim under your policy) are injured in an automobile accident, please contact us immediately to report the loss. You can reach us 24 hours a day, seven days a week at 1-800-841-3000.

Your Personal Injury Protection (PIP) examiner will contact you to discuss your injuries and obtain the names of any medical providers you may be treating with. Your PIP examiner will also send you a No Fault application for you to complete.

Pursuant to N.J.A.C. 11:3-4.4, the insured and the injured party or their medical provider must provide us with information regarding the facts of the accident, nature and cause of the injury, the diagnosis and the anticipated course of treatment. This must be provided to us as promptly as possible after the accident and periodically thereafter. Failure to provide this required information can result in a penalty co-payment of up to 25% if received after 30 days from the accident or up to 50% if received 60 days or more after the accident.

### DECISION POINT REVIEW AND PRE-CERTIFICATION REQUIREMENTS

**Please note:** Under the provisions of your policy and applicable New Jersey regulations, Decision Point Reviews and/or Pre-certification of specified medical treatment and testing is required in order for medically necessary expenses to be fully reimbursable under the terms of your policy. The following questions and answers only provide an overview of Decision Point Reviews and Pre-certification requirements. You should read your policy for the actual Pre-certification requirements as well as other policy terms and conditions.

**Treatment in the first 10 days after an accident and emergency care does not require Decision Point Review or Pre-certification. However, for benefits to be paid, the treatment must be medically necessary. This is true in all events.**

Question: What is a Decision Point Review?

Answer: The New Jersey Department of Banking and Insurance (the "Department") has published standard courses of treatment, **Care Paths**, for soft tissue injuries of the neck and back, collectively referred to as the "Identified Injuries". These Care Paths provide your health care provider with general guidelines for treatment and diagnostic testing as to these injuries. In addition, the Care Paths require that treatment be evaluated at certain intervals called **Decision Points**. At Decision Points, your health care provider must provide us information about any further treatment or test required. This is called **Decision Point Review**. During the Decision Point Review process, all services requested are evaluated by medical professionals to ensure the level of care you are receiving is medically necessary for your injuries. This does not mean that you are required to obtain our approval before consulting your medical provider for your injuries. However, it does mean that your medical provider is required to follow the Decision Point Review requirements in order for you to receive maximum reimbursement under the policy. In addition, the administration of any test listed in N.J.A.C. 11:3-4.5(b) 1-10 also requires Decision Point Review, regardless of the diagnosis. The **Care Paths** and accompanying rules are available on the Internet at the Department's website at [www.nj.gov/dobi/aicrapg.htm](http://www.nj.gov/dobi/aicrapg.htm) or can be obtained by contacting Premier Prizm Solutions, LLC at 1-856-596-5600.

Question: What is Pre-certification?

Answer: Pre-certification is a medical review process for the specific services, tests or equipment listed below in (1)-(13). During this process all services, tests or equipment requested are evaluated by medical professionals to ensure the level of services, tests or equipment you are receiving are medically necessary for your injuries. This does not mean that you are required to obtain our approval before consulting your medical provider for your injuries. However, it does mean that your medical provider is required to follow the Pre-certification requirements in order for you to receive maximum reimbursement under the policy.

1. Non-emergency inpatient and outpatient hospital care
2. Non-emergency surgical procedures
3. Extended Care Rehabilitation Facilities
4. 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

## Decision Point Review & Pre-Certification Requirements

5. Physical, Occupational, Speech, Cognitive, Rehabilitation or other restorative therapy or therapeutic or body part manipulation except as provided for identified injuries in accordance with Decision Point Review
6. Outpatient psychological/psychiatric treatment/testing or services
7. All pain management services except as provided for identified injuries in accordance with Decision Point Review
8. Home Health Care
9. Acupuncture
10. Durable Medical Equipment (including orthotics or prosthetics) with a cost or monthly rental in excess of \$100.00, or rental in excess of 30 days
11. Non-Emergency Dental Restorations
12. Temporomandibular disorder, any oral facial syndrome
13. Non-medical products, devices, services and activities, and associated supplies, not exclusively used for medical purposes or as durable medical goods, with an aggregate cost or monthly rental in excess of \$100.00 or rental in excess of 30 days, including but not limited to:
  - (a) Vehicles;
  - (b) Modification to vehicles;
  - (c) Durable goods;
  - (d) Furnishings;
  - (e) Improvements or modifications to real or personal property;
  - (f) Fixtures;
  - (g) Spa/gym memberships;
  - (h) Recreational activities and trips;
  - (i) Leisure activities and trips.

Question: What do I need to do to comply with the Decision Point Review and Pre-certification requirements in my policy?

Answer: Just provide us with the name(s) of your medical providers. We will then contact them to explain the entire process. You should also give your medical provider a copy of the "Dear Doctor Letter" (starting on page 4).

Question: How does the Decision Point Review/Pre-certification process work?

Answer: In order for Premier Prizm Solutions, LLC to complete the review, your health care provider is required to submit all requests on the "Attending Physician's Treatment Plan" form in accordance with order number A04-143. A copy of this form can be found on the DOBI web site [www.nj.gov/dobi/aicrapg.htm](http://www.nj.gov/dobi/aicrapg.htm), Premier Prizm Solutions, LLC web site is [www.PremierPrizm.com](http://www.PremierPrizm.com) or by contacting Premier Prizm Solutions, LLC at 856-596-5600.

The health care provider should submit the completed form, along with a copy of their most recent/appropriate progress notes and the results of any tests relative to the requested services to Premier Prizm Solutions, LLC via fax at 856- 596-6300 or mail to the following address: Premier Prizm Solutions, LLC, 10 East Stow Road, Suite 100, Marlton, NJ 08053, ATTN.: Pre- Certification Department. The phone number is 856-596-5600.

The review will be completed within three (3) business days of receipt of the necessary information and notice of the decision will be communicated to both you and your health care provider by telephone, fax and/or confirmed in writing. If your health care provider is not notified within 3 business days, they may continue your test or course of treatment until such time as the final determination is communicated to them. Similarly, if an independent medical examination should be required, they may continue your tests or course of treatment until the results of the examination become available.

**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.**

## INDEPENDENT MEDICAL EXAMS

Question: What are the requirements and consequences if I am requested to attend an Independent Medical Exam?

Answer: If the need arises for Premier Prizm Solutions, LLC to utilize an independent medical exam during the decision point review/pre- certification process, the guidelines in accordance with New Jersey Regulations will be followed. This includes but is not limited to: prior notification to the injured person or his or her designee, scheduling the exam within seven calendar days of the receipt of the Attending Physician's Treatment Plan form (unless the injured person agrees to extend the time period), having the exam conducted by a provider in the same discipline, scheduling the exam at a location reasonably convenient to the injured person, and providing notification of the decision within three business days after attendance of the exam.

## Decision Point Review & Pre-Certification Requirements

If the examining provider prepares a written report concerning the examination, you or your designee shall be entitled to a copy upon written request.

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

### RECONSIDERATION PROCESS

Question: Can my health care provider appeal the Decision Point Review or Pre-certification decision?

Answer: Yes. If Premier Prizm Solutions, LLC fails to certify a request, the clinical rationale for this determination is available to you and/or your health care provider upon written request. If your health care provider would like to have the decision reconsidered, they can participate in Premier Prizm Solutions, LLC internal review process by notifying Premier Prizm Solutions, LLC of their intention to participate in the reconsideration process, by phone at 856-596-5600, via fax at 856-596-6300, or in writing at 10 East Stow Road, Suite 100, Marlton, NJ 08053. If your health care provider has accepted an assignment of benefits, they are required to participate in this process. In accordance with the plan, the reconsideration decision will be provided to your health care provider within ten (10) days of the request. This process will afford your health care provider the opportunity to discuss the appeal with a "similar discipline" Medical Director.

### VOLUNTARY UTILIZATION PROGRAM

Question: Does the plan provide voluntary networks for certain services, tests or equipment?

Answer: In accordance with the regulations, the plan includes a voluntary utilization program for:

1. Magnetic Resonance Imagery;
2. Computer Assisted Tomography;
3. Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of \$100.00, or rental in excess of 30 days;
4. Prescription Drugs;
5. The electro diagnostic tests listed in N.J.A.C. (11:3-4.5(b) 1 through 3, unless performed in conjunction with a needle EMG by the treating provider.

Question: How do I gain access to one of these networks?

Answer: Premier 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 by the treating provider). If the injured party utilizes 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 a needle EMG, the 30% co-payment will not apply. In cases of prescriptions, the \$10.00 co-pay of GEICO will be waived if obtained from one of the pre-approved networks.

For *diagnostic tests* of MRI's and CAT Scans, the approved voluntary network that can be utilized is either *Atlantic Imaging* or *One Call*. Once a diagnostic test that is subject to pre-approval through Decision Point Review/Pre-Certification is authorized, a representative of Premier Prizm will contact one of the vendors and forward the information to them for scheduling purposes. A representative from the diagnostic facility will contact the injured party and schedule the test at a time and place convenient to them.

For *Durable Medical Equipment* with a cost or monthly rental over \$100.00, the approved network is *Progressive Medical, Inc.* Once a request for Durable Medical Equipment that is subject to pre-approval through Decision Point Review/Pre-Certification is authorized, a representative of Premier Prizm will contact Progressive Medical and forward the information to them. The equipment will be shipped to the injured party from Progressive Medical, 24 hours after the request is received.

When the injured party is in need of prescription drugs, the approved networks are MyMatrixx and Jordan Reese. A pharmacy card will be issued that can be presented at numerous participating pharmacies. A list of participating pharmacies will be mailed to the injured party once the need for a prescription has been identified.

## Decision Point Review & Pre-Certification Requirements

For *Electrodiagnostic Testing*, the approved networks are *One Call* and *Atlantic Neurodiagnostic Group*. Once an electrodiagnostic test that is subject to pre-approval through Decision Point Review/Pre-Certification is authorized, a representative of Premier Prizm will contact one of the vendors and forward the information to them for scheduling purposes. A representative from the diagnostic facility will contact the injured party and schedule the test at a time and place convenient to them. When Electrodiagnostic tests are performed by the treating provider, in conjunction with a needle EMG, the 30% co-payment will not apply.

**In addition to securing a list of preferred provider networks through the process outlined in the paragraph above, visit Premier Prizm Solutions, LLC website @ [www.PremierPrizm.com](http://www.PremierPrizm.com), contact Premier Prizm Solutions, LLC by phone at 856-596-5600, via fax at 856-596-6300, or in writing at 10 East Stow Road, Suite 100, Marlton, NJ 08053.**

### PENALTY CO-PAYMENTS

**Question:** Why would payment of my bills for health care services, tests and durable medical equipment be subject to additional co-pay, and how much is it?

**Answer:** Failure of your health care provider to comply with the Decision Point Review/Pre-certification provisions of the plan, including failure to submit a request for Decision Point Review/Pre-certification or failure to provide clinically supported findings that corroborate a request, will result in a co-payment of 50% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment and tests and equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

If you do not utilize a network provider/facility to obtain those services, tests or equipment listed in the voluntary utilization review program section, payment for those services rendered will result in a co-payment of 30% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment, tests and equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

Any reduction shall be applied prior to any other deductible or co-payment requirement.

### ASSIGNMENT OF BENEFITS

**Question:** Can I assign my benefits?

**Answer:** Yes, but only to a provider of service benefits. Please read the Assignment of PIP Benefits section in your policy carefully. All assignments are subject to all requirements, duties and conditions of the policy, including, but not limited to: Internal Appeals Dispute Resolution Process; Pre-certification, Decision Point Reviews, exclusions, deductibles and co-payments.

**NO COVERAGE IS PROVIDED BY THIS DOCUMENT OR THE QUESTIONS AND ANSWERS CONTAINED IN IT. THIS DOCUMENT DOES NOT REPLACE ANY OF THE PROVISIONS OF YOUR POLICY. YOU SHOULD READ YOUR POLICY CAREFULLY FOR COMPLETE INFORMATION AS TO THE TERMS OF YOUR COVERAGE. IF THERE IS ANY CONFLICT BETWEEN THE POLICY AND THIS SUMMARY, THE PROVISIONS OF THE POLICY SHALL PREVAIL.**

***ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.***

Government Employees Insurance Company

GEICO General Insurance Company

GEICO Indemnity Company

GEICO Casualty Company

P. O. Box 986

Marlton, NJ 08053-0986

1-800-841-3000



P.O. Box 986, Marlton, NJ 08053-0986

- Government Employees Insurance Company
- GEICO General Insurance Company
- GEICO Indemnity Company
- GEICO Casualty Company

Date:

Doctor Name  
Address  
City, State, Zip

Re: Claimant Name  
Claim Number  
Date of Accident

Dear Doctor:

Personal Injury Protection (PIP) is the portion of the auto policy that provides coverage for medical expenses. These medical expenses are subject to policy limits, deductibles, co-payments and any applicable medical fee schedules. Additionally, these medical expenses must be for services that are deemed medically necessary and causally related to the motor vehicle accident. With the adoption of the Automobile Cost Reduction Act of 1998, several important changes have been made in the way a claim is processed. Additional information regarding Decision Point Review/Pre-Certification can be accessed on the Internet at the New Jersey Department of Banking and Insurance's website at <http://www.nj.gov/dobi/filings.htm>

Premier Prizm Solutions, LLC has been selected by GEICO to implement their plan as required by the Automobile Cost Reduction Act. Premier Prizm will review treatment plan requests for Decision Point Review/Pre-Certification, perform Medical Bill Repricing and Audits of provider bills, coordinate Independent Medical Exams and Peer Reviews, and provide Case Management Services.

If certain medically necessary services are preformed without notifying GEICO or Premier Prizm, a penalty/co-payment may be applied. Medical care rendered in the first 10 days following the covered loss or any care received during an emergency situation is not subject to Decision Point Review/Pre-Certification.

**The Plan Administrator of this plan is:**

Premier Prizm Solutions, LLC  
10 East Stow Road  
Suite 100  
Marlton, New Jersey 08053  
Phone Number: 856-596-5600  
Fax Number: 856-596-6300  
Email Address: AICRA @PremierPrizm.com

**Submission of Treatment Plan Requests for Decision Point Review/PreCertification**

Please complete the "Attending Provider Treatment Plan" form and forward with any applicable medical documentation to Premier Prizm by fax (856-596-6300), or mail (10 East Stow Road, Suite 100, Marlton, NJ 08053) or email to Treatment Requests@PremierPrizm.com. This form can be accessed on Premier Prizm's web site at [www.PremierPrizm.com](http://www.PremierPrizm.com). Any questions regarding your treatment request can be directed to Premier Prizm at 856-596-5600 during regular business hours of Monday through Friday 8:00 AM to 5:00 PM, EST except for Federally Declared Holidays.

**Decision Point Review**

Pursuant to 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, collectively referred to as **identified injuries**. Additionally, guidelines for certain diagnostic tests have been established by the New Jersey Department of Banking and Insurance according to N.J.A.C. 11:3-4. Decision Points are intervals within the Care Paths where treatment is evaluated for a decision about the continuation or choice of further treatment the attending physician provides. At Decision Points, the eligible injured person or the health care provider must provide Premier Prizm with information regarding further treatment the health care provider intends to provide.

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**

1. Needle Electromyography (EMG)
2. Somatosensory Evoked Potential (SSEP)
3. Visual Evoked Potential (VEP)
4. Brain Audio Evoked Potential (BAEP)
5. Brain Evoked Potentials (BEP)
6. Nerve Conduction Velocity (NCV)
7. H-Reflex Studies
8. Electroencephalogram (EEG)
9. Videofluoroscopy
10. Magnetic Resonance Imaging (MRI)
11. Computer Assisted Tomograms (CT, CAT Scan)
12. Dynatorm/Cybex Station/Cybex Studies and any range of muscle motion testing
13. Sonogram/Ultrasound
14. Brain Mapping
15. Thermography/Thermograms

**Pre-Certification**

Pursuant to N.J.A.C. 11:3-4.7, the New Jersey Department of Banking and Insurance, Premier Prizm's Pre-Certification Plan requires pre-authorization of certain treatment/diagnostic tests or services. Failure to pre-certify these services may result in penalties/co-payments even if services are deemed medically necessary. If the eligible injured person does not have an Identified Injury, you as the treating provider are required to obtain Pre-Certification of treatment, diagnostic tests, services, prescriptions, durable medical equipment or other potentially covered expenses as noted below:

1. Non-emergency inpatient and outpatient hospital care
2. Non-emergency surgical procedures
3. Extended Care Rehabilitation Facilities
4. 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.
5. Physical, Occupational, Speech, Cognitive, Rehabilitation or other restorative therapy or therapeutic or body part manipulation except as provided for identified injuries in accordance with Decision Point Review.
6. Outpatient psychological/psychiatric treatment/testing or other services
7. All pain management services except as provided for identified injuries in accordance with Decision Point Review.
8. Home Health Care
9. Acupuncture
10. Durable Medical Equipment (including orthotics or prosthetics) with a cost or monthly rental in excess of \$100.00 or rental in excess of 30 days
11. Non-Emergency Dental Restorations
12. Temporomandibular disorder; any oral facial syndrome
13. Non-medical products, devices, services, and activities, and associated supplies, not exclusively used for medical purposes or as durable medical goods, with an aggregate cost or monthly rental in excess of \$100.00 or rental in excess of 30 days, including but not limited to:
  - (a) Vehicles
  - (b) Modifications to vehicles
  - (c) Durable goods
  - (d) Furnishings
  - (e) Improvements or modifications to real or personal property
  - (f) Fixtures
  - (g) Spa/gym memberships
  - (h) Recreational activities and trips
  - (i) Leisure activities and trips

**Decision Point Review/Pre-Certification Process**

On behalf of GEICO, Premier Prizm will review all treatment plan requests and medical documentation submitted. A decision will be rendered within three business days of receipt of a completed "Attending Provider Treatment Plan" form request with supporting medical documentation. If additional information is requested, the decision will be rendered within three days of our receipt of the additional information. In the event that GEICO Insurance Company or Premier Prizm does not receive sufficient medical information accompanying the request for treatment, diagnostic tests or services to make a decision, an administrative denial will be rendered, until such information is received.

### **Sample Doctor's Notification Letter**

If a decision is not rendered within three business days of receipt of an "Attending Provider Treatment Plan" form, you, as the treating health care provider, may render medically necessary treatment until a decision is rendered. Please note that the denial 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.

### **Voluntary Pre-Certification**

We encourage you, as the treating health care provider, to participate in a voluntary pre-certification process by submitting a comprehensive treatment plan to Premier Prizm for all services provided. Premier Prizm will utilize nationally accepted criteria to authorize a mutually agreeable course of treatment. In consideration for your participation in this voluntary pre-certification process, the bills you submit consistent with the agreed plan will not be subject to review or audit as long as they are in accordance with the policy limits, deductibles, and any applicable PIP fee schedule. This process increases the communication between the patient, provider and Premier Prizm to develop a comprehensive treatment plan with the avoidance of unnecessary interruptions in care.

### **Independent Medical Examination**

Premier Prizm or GEICO may request an Independent Medical Examination. At times, this examination may be necessary to reach a decision in response to the treatment plan request by the treating provider. This examination will be scheduled with a provider in the same discipline and at a location reasonably convenient to the injured person. Premier Prizm will schedule the appointment for the examination within 7 days of the day of the receipt of the request unless the insured/designee otherwise agrees to extend the time frame. Medically necessary treatment may proceed while the examination is being scheduled and until the Independent Medical Examination results become available. Upon completion of the Independent Medical Examination, you, as the treating provider, will be notified of the results by fax or mail within three business days after the examination. If the examining provider prepares a written report concerning the examination, the insured or their designee shall be entitled to a copy upon written request.

Premier Prizm will notify the injured party or designee and the treating provider of the scheduled physical or mental 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 physician's treatment plan will not be reimbursable as a consequence for failure to comply with the plan.

### **Voluntary Network Services**

Premier 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 by the treating provider). If the injured party utilizes 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, the 30% co-payment will not apply. In cases of prescriptions, the \$10.00 co-pay of GEICO will be waived if obtained from one of the pre-approved networks.

For diagnostic tests of MRI's and CAT Scans, the approved voluntary network that can be utilized is either *Atlantic Imaging or One Call*. Once a diagnostic test that is subject to pre-approval through Decision Point Review/Pre-Certification is authorized, a representative of Premier Prizm will contact one of the two vendors and forward the information to them for scheduling purposes. A representative from the diagnostic facility will contact the injured party and schedule the test at a time and place convenient to them.

For *Durable Medical Equipment* with a cost or monthly rental over \$100.00, the approved network is *Progressive Medical, Inc.* Once a request for Durable Medical Equipment that is subject to pre-approval through Decision Point Review/Pre-Certification is authorized, a representative of Premier Prizm will contact Progressive Medical and forward the information to them. The equipment will be shipped to the injured party from Progressive Medical, 24 hours after the request is received.

When the injured party is in need of prescription drugs, the approved networks are *MyMatrixx* and *Jordan Reese*. A pharmacy card will be issued that can be presented at numerous participating pharmacies. A list of participating pharmacies will be mailed to the injured party once the need for a prescription has been identified.

For *Electrodiagnostic Testing*, the approved networks are *One Call* and *Atlantic Neurodiagnostic Group*. Once an electrodiagnostic test that is subject to pre-approval through Decision Point Review/Pre-Certification is authorized, a representative of Premier Prizm will contact one of the vendors and forward the information to them for scheduling purposes. A representative from the diagnostic facility will contact the injured party and schedule the test at a time and place convenient to them. When Electrodiagnostic tests are performed by you, in conjunction with a needle EMG, the 30% co-payment will not apply.

**Penalty Notification**

Failure to submit requests for Decision Point Review or Pre-Certification where required, or failure to submit clinically supported findings that support the treatment, diagnostic testing, or durable medical goods requested will result in a co-payment penalty of 50%. This co-payment is in addition to any deductible or co-payment stated in the insured's policy.

If you do utilize a network provider/facility to obtain those services, tests or equipment listed in the voluntary utilization review program section, payment for those services rendered will result in a co-payment of 30% (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment, tests and equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy.

Any reduction shall be applied prior to any other deductible or co-payment requirement.

**Assignment of Benefits**

Health care providers that accept assignment for payment of benefits should be aware that they are required to hold harmless the injured person, insured or the insurance carrier for any reduction of benefits caused by the provider's failure to comply with the terms of the decision point/pre-certification plan. In addition, you must agree to submit disputes to our Internal Appeals Process prior to submitting any disputes through National Arbitration Forum as per N.J.A.C. 11:3-5. Failure to comply with the Decision Point Review/Pre-Certification Plan or the requirements to follow the Internal Appeals Process prior to filing litigation including arbitrations will void any and all prior assignment of benefits under this policy. Should the assignee choose to retain an attorney to handle the Internal Appeals Process, they do at their own expense.

**INTERNAL APPEAL PROCESS**

The Internal Appeal Process shall be utilized before filing arbitration.

***All appeals concerning a Decision related to a Treatment Request***

Disputes must be submitted to our Plan administrator for reconsideration. If a request for medical services is not approved the treating provider can request a reconsideration by the Physician Advisor who rendered the decision (or a designated Physician Advisor in his absence) or by Premier Prizm's Medical Director. Appeals are to be submitted as follows:

1. For appeals regarding a decision related to a treatment request, notification to Premier Prizm, the Plan administrator, needs to occur within 10 business days of the receipt of the decision in question. This appeal must be made in writing by fax, mail or by accessing the Internal Appeals Form on the web site, [www.PremierPrizm.com](http://www.PremierPrizm.com), at which point further documentation can be discussed with a physician advisor.
2. This appeal must contain the treating provider's signature and the reason for the appeal. The written dispute shall include, but not limited to, copies of all supporting documentation with reason for reconsideration. A telephone conference with the Physician Advisor or the Medical Director and the treating provider is conducted within 10 business day of the receipt of the appeal. Premier Prizm's response to the appeal will be communicated to the requesting provider in writing by fax within ten business days of the receipt. An Internal Appeals Form can be accessed on web site at [www.PremierPrizm.com](http://www.PremierPrizm.com).
3. It may be determined than 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 insured agrees to extend the time period. The examination shall be held in a location convenient to the insured with a **health care provider** of the same specialty as the treating provider.
4. Prizm's written response to the appeal will be communicated to the requesting provider By fax or mail within 10 business days of receipt of request or within 3 days following the Independent Medical Exam.

**Appeals Regarding any issue other than a Decision Related to a Treatment Request.**

All appeals which do not concern a decision related to a treatment request shall be submitted to Geico as follows:

Disputes must be submitted to our Plan administrator, Premier Prizm for reconsideration. Issues not related to a request for decision point review or precertification can include, but are not limited to, bill review or payment for services. This appeal must be signed by the treating provider and submitted in writing stating the issue being disputed along with supporting documentation. Premier Prizm's written response to this appeal will be communicated to the requesting provider by fax or mail within 10 business days of receipt of request. Appeals are to be submitted, in accordance with the plan as follows:

For any appeal or issue not related to a request for Decision Point Review or Precertification, (including but not limited to reimbursement) a treating provider who has accepted an assignment of benefits must submit a written request for Internal Appeals stating the issue in dispute along with supporting documentation at least 30 days prior to initiating arbitration. Should the assignee choose to retain an attorney to handle the Appeals Process, they do so at their own expense.

All other disputes not resolved through Premier Prizm's Internal Appeals process must be submitted to us as follows:

1. Written notice of the dispute and request for Appeal shall be submitted to GEICO via certified mail/ return receipt requested or via delivery mail service providing proof of delivery. Proof of receipt by us must be provided to GEICO, upon request.



2. Geico shall have 30 days from receipt notice and supporting documents or the statutory minimum pursuant to N.J.S.A. 39:6A-5(g), whichever is greater to resolve the dispute. During this time the provider shall cooperate with the investigation of the matter in question and negotiate in good faith with GEICO in an effort to resolve the dispute amicably.
3. After 30 days, if good faith efforts of both parties fail to bring resolution to the dispute, the provider or assignee may proceed to arbitrate the matter. Requests for dispute resolution may include a request for review by a Medical Review Organization. However, if a determination of benefits coverage has not been made or, if we contend that we do not owe coverage under this policy or that we are not required to provide benefits under this policy because of a misrepresentation of a material fact made by an insured, an injured party or anyone else seeking coverage and/or benefits from us, then we shall, at our sole option, have the right to have that dispute resolved in either the Superior Court of New Jersey or by a dispute resolution organization.
  - a. If the provider or assignee retains counsel to represent them during the Appeal process, they do so at their own expense. No counsel fees or any other costs incurred during the Appeal process shall be compensable irrespective of whether the dispute is resolved on appeal or litigated.
  - b. The provider or assignee agrees to hold harmless and indemnify Geico for any legal fees and/or costs awarded should the provider/assignee litigate any matter prior to fulfilling the Dispute Resolution requirements of the policy including utilization of the Internal Appeals process.

**Dispute Resolution Process**

If we or any person seeking Personal Injury Protection Coverage do not agree as to the recovery of Personal Injury Protection Coverage under the policy, then the matter shall be submitted to dispute resolution, on the initiative of any party to the dispute, in accordance with New Jersey law or regulation.

Any request for dispute resolution may include a request for review by a medical review organization.

The staff at Premier Prizm remains available to you and your patient in order to assist with Decision Point Review/ Pre-Certification Process.

Sincerely,

Government Employees Insurance Company