

***PROGRESSIVE***<sup>®</sup>

**Important Notice to  
Policyholders—  
Medical Protocols**

**Important Notice**  
**Medical Protocols**  
**Progressive Decision Point Review Plan<sup>1</sup>**

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

The Automobile Insurance Cost Reduction Act became law in May 1998 and established certain obligations that must be satisfied so that coverage for medically necessary treatment, diagnostic testing, and durable medical equipment arising from injuries sustained in an automobile accident may be provided. Failure to abide by the following obligations may affect the authorization of medical treatment, diagnostic testing, and durable medical equipment.

1. Pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance has published standard courses of treatment, identified as “Care Paths,” for injuries of the neck or back, collectively referred to as the **identified injuries**. The Care Paths provide that treatment be evaluated at certain intervals called **decision points**. At **decision points, insured persons** or their **health care providers** must provide **us** with information about further treatment the provider intends to pursue. This is called **decision point review**. To view online, **our** Decision Point Review Plan is available at [www.progressive.com/suppliers](http://www.progressive.com/suppliers) under Auto Claims. The Care Paths and accompanying rules are available on the New Jersey Department of Banking and Insurance website at [www.state.nj.us/dobi/pipinfo/aicrapg.htm](http://www.state.nj.us/dobi/pipinfo/aicrapg.htm) or from the claims representative. If an **insured person** or their attending **health care provider** fails to submit requests for **decision point review** or fails to submit legible clinically supported findings that establish the need for treatment, diagnostic testing, or durable medical equipment requested, payment of medical bills may be subject to a penalty co-payment of up to 50% even if the services are later determined to be medically necessary.
2. Certain diagnostic testing that is considered to be medically necessary also requires **decision point review** pursuant to N.J.A.C. 11:3-4, regardless of diagnosis, and **we** must be provided with written support establishing the need for the test before **we** can consider authorizing it. The list of diagnostic tests requiring **our** prior authorization and a list of diagnostic tests that the law prohibits **us** from authorizing under any circumstances are also included in this information packet. If diagnostic testing requests are not submitted for **decision point review** or if **we** are not provided with legible clinically supported findings that support the treatment, diagnostic testing, or durable medical equipment requested, payment may be subjected to a penalty co-payment of up to 50% even if the services are later determined to be medically necessary.

<sup>1</sup> Terms in bold are defined terms in the insurance policy contract. “Insured Person” is subject to the definition under Part II—Personal Injury Protection (PIP) Coverage.

### 3. **WRITTEN SUPPORT REQUIRED BEFORE TREATMENT, TESTING, OR DURABLE MEDICAL EQUIPMENT CAN BE CONSIDERED FOR COVERAGE**

Pursuant to N.J.A.C. 11:3-4.7(d), all attending **health care providers** must use the Attending Provider Treatment Plan (APTP) form to submit **decision point review** and **precertification** requests. No other form will be accepted. A copy of the APTP form is available at [www.state.nj.us/dobi/pipinfo/aicrapg.htm](http://www.state.nj.us/dobi/pipinfo/aicrapg.htm) or by contacting the assigned PIP claims representative.

A properly submitted APTP form must be completed in its entirety and must include the injured party's full name, date of birth, the claim number, the date of accident, diagnoses/ICD code(s), each CPT code requested, including frequency, duration/treatment period, and the signature of the requesting physician. Requests that are not submitted on this form will be denied for insufficient information and a completed form will be requested and required.

In addition, **we** require supplemental information for all requests for surgical procedures (CPTs 10000-69999), 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 RNFAs as supported by CMS guidelines, anticipated post-operative services and care not included in the global fee, such as therapy, diagnostic testing, and/or durable medical equipment. This information must be submitted on the Surgery Precertification Request NJ No-Fault Claims form, which is available at [www.progressive.com/suppliers](http://www.progressive.com/suppliers) under Auto Claims or by contacting the assigned PIP claims representative. Requests for surgeries that do not include the necessary information will be denied as deficient until the additional information required is supplied.

Written documentation to be supplied to **us** must be legible and clinically supported and establish that an attending **health care provider**, prior to selecting, performing, or ordering the administration of a treatment, diagnostic testing, or durable medical equipment has:

- a) Personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment, diagnostic testing, or durable medical equipment;
- b) Physically examined the patient, including making an assessment of any current and/or historical subjective complaints, observations, objective findings, neurologic indications, and physical tests;
- c) Considered the results of any and all previously performed tests that relate to the injury and which are relevant to the proposed treatment, diagnostic testing, or durable medical equipment; and
- d) Recorded and documented these observations, positive and negative findings, and conclusions on the patient's medical records.

**Please note:** An APTP form may not be submitted by and will not be accepted from a provider of service benefits who did not personally physically examine the patient. This includes, but is not limited to, DME suppliers, imaging facilities, Ambulatory Surgery Centers, and pharmacies. An APTP form must be submitted by the attending **health care provider** ordering the requested treatment, diagnostic testing, or durable medical equipment.

4. **We require precertification** for the following services and/or conditions for treatment, diagnostic testing, or durable medical equipment not included in the Care Paths or subject to **decision point review** pursuant to N.J.A.C. 11:3-4:
- a) Non-emergency inpatient or outpatient hospital care (including the appropriateness and duration of the hospital stay);
  - b) Non-emergency surgery (performed in a hospital, freestanding surgical center, office, etc.), including implants and post-operative care/supplies not included in the global fee period. Pursuant to N.J.A.C. 11:3-29.4 et seq., global fee periods and the necessity for co-surgeons and assistant surgeons will be determined based upon the Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule and Medicare Claims Manual, which can be found at <http://www.cms.gov>;
  - c) 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 cost, in excess of \$100, or used for a rental period in excess of 30 calendar days, including but not limited to:
    - 1) Vehicles;
    - 2) Modifications to vehicles;
    - 3) Durable goods;
    - 4) Furnishings;
    - 5) Improvements, modifications, or alterations to real or personal property;
    - 6) Fixtures;
    - 7) Spa/gym memberships;
    - 8) Recreational activities and trips;
    - 9) Leisure activities and trips;
  - d) Durable medical equipment (including orthotics and prosthetics) costing greater than \$50, or rental longer than thirty (30) days;
  - e) Extended care and rehabilitation;
  - f) Home health care;
  - g) Infusion therapy;
  - h) Outpatient psychological/psychiatric testing and/or services, including biofeedback;
  - i) All physical, occupational, speech, cognitive or other restorative therapy, or body part manipulation;
  - j) All pain management services;
  - k) Non-emergency dental restoration;
  - l) Temporomandibular disorders or any oral facial syndrome;

- m) Outpatient care for soft tissue/disc injuries of the insured's neck, back, or related structures not included within the diagnoses covered by the Care Paths;
- n) Computerized muscle testing;
- o) Current perceptual testing;
- p) Temperature gradient studies;
- q) Work hardening;
- r) Carpal Tunnel Syndrome;
- s) Vax D and DRX;
- t) Podiatry;
- u) Audiology;
- v) Bone Scans;
- w) Non-emergency transportation services;
- x) Schedule II, III and IV Controlled Substances, as defined by the Drug Enforcement Administration (DEA), when prescribed for more than three months;
- y) Prescriptions, including but not limited to Schedule II, III and IV Controlled Substances, where charged amount or billed amount is more than \$50 for a single fill and/or a 30-day supply;
- z) Compound drugs and compounded prescriptions;
- aa) Any and all procedures that use an unspecified CPT, CDT, DSM IV and/or HCPC code; and
- bb) Laboratory or pathology testing.

The failure to seek **precertification** for such services or the failure to submit legible clinically supported findings that establish the need for the treatment, diagnostic testing, or durable medical equipment requested will result in the imposition of a 50% co-payment penalty, even if the services are later determined to be medically necessary.

## 5. TESTS WHICH REQUIRE DECISION POINT REVIEW

- a) Needle EMG;
- b) Somatosensory evoked potential (SSEP), visual evoked potential (VEP), brain audio evoked potential (BAEP) or brain evoked potential (BEP), nerve conduction velocity (NCV) and H-reflex Study;
- c) Electroencephalogram (EEG);
- d) Videofluoroscopy;
- e) Magnetic resonance imaging (MRI);
- f) Computer assisted tomographic studies (CT, CAT Scan)
- g) Dynatron/cyber station/cybex;
- h) Sonograms/ultrasound;
- i) Thermography/thermograms;
- j) Brain mapping; and
- k) Any other diagnostic test that is subject to the requirements of a **decision point review** plan by New Jersey law or regulation.

6. **HOW TO SUBMIT DECISION POINT/PRE CERTIFICATION REQUESTS:**

**Decision point review/precertification** requests must be faxed to **us** at:

**1-866-841-8312**

7. **We** encourage **you** to submit comprehensive treatment plans to avoid periodic reviews when continued treatment is considered medically necessary for an extended period of time. As long as treatment is consistent with the approved plan, additional notification at **decision points** and for treatment, testing, or durable medical equipment requiring **precertification** is not required, except as designated in the approval letter. The **insured person** or the **health care provider** must submit a request for **decision point review** or **precertification** for any treatment or testing that varies from the approved treatment plan.
8. Upon receipt of proper written documentation in accordance with **decision point review** and **precertification** requirements, **we** will either:
- Authorize the treatment, diagnostic testing, or durable medical equipment;
  - Deny and/or modify the treatment, diagnostic testing, or durable medical equipment;
  - Request additional medical documentation; or
  - Advise that an Independent Medical Examination will be scheduled.

If **we** fail to do at least one of these four things within three (3) business days after receipt of a request submitted on the appropriate form(s), the proposed treatment, diagnostic testing, and/or durable medical equipment is deemed to be authorized until a final determination is communicated to **you**. Telephonic responses will be followed up with a written authorization, denial, or request for more information within three (3) business days. The decision to deny a request based on medical necessity will be made by a physician or a dentist.

If an Independent Medical Examination is requested, the scheduling of the appointment date for the physical examination will be completed within seven (7) calendar days from the date that **we** notified the requesting party that an Independent Medical Examination will be scheduled unless the injured person agrees with **us** to extend the time period. The physical examination itself will be scheduled to occur within thirty-five (35) calendar days from receipt of the notice.

The Independent Medical Examination will be conducted by a **health care provider** within the same specialty as the **insured person's** treating **health care provider** and will be conducted in a location reasonably convenient to the **insured person**. Results of the Independent Medical Examination and the determination regarding the **precertification** request will be submitted to the **insured person** in

writing and to the **health care provider** in writing within three (3) business days after the examination. Please note that medically necessary treatment may proceed while the Independent Medical Examination is being scheduled and until the results are available. 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 of the report upon request.

At **our** request, the **insured person** must provide all medical records and diagnostic studies/tests available before or at the time of the scheduled examination. Failure to provide the required medical records and/or diagnostic studies/tests will be considered an unexcused failure to attend the Independent Medical Examination. Failure to attend a scheduled examination without first furnishing notice at least three (3) business days prior to the examination date of the need to cancel and re-schedule will be considered an unexcused failure to attend. Rescheduled exams will be scheduled to occur within thirty (30) calendar days of the originally scheduled examination date. Failure to attend, with or without prior notice, any rescheduled examination will be considered an unexcused failure to attend. If the injured person has two (2) or more unexcused failures to attend a scheduled exam, or three (3) failures in total to attend a scheduled exam, notification will be immediately sent to the injured person or to his or her designee, and all providers treating the injured person for the diagnosis (and related diagnosis) contained in the Attending Provider Treatment Plan form. The 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 Provider Treatment Plan form will not be reimbursable as a consequence for failure to comply with the plan.

9. **Emergency care** treatment or testing does not require **our** prior authorization. **Decision point review** and **precertification** requirements do not apply within ten (10) days of the insured event.
10. Reimbursement for medically necessary expenses is subject to the policy deductible, co-payment(s), policy limits, the New Jersey PIP Fee Schedule, and the billing and coding guidelines established by the American Medical Association, outlined in the Current Procedural Terminology (CPT) guide and the provisions of N.J.A.C. 11:3-29.
11. **Please note:** Authorized testing, treatment, and/or durable medical equipment is approved only for the range of dates noted in determination letter(s).
12. **Expired Authorizations:** Any approved treatment, testing, and/or durable medical equipment performed/supplied after the authorization period expires (last date in the range of dates indicated in the determination letter) will be considered unauthorized and subject to a penalty co-payment of 50%, even if the services are determined to be medically necessary.

13. **Hours of Operation:** Regular business hours are Monday through Friday 8:00 a.m. - 5:00 p.m. All requests for pre-authorization on weekends and holidays will be handled on the next business day. Submitting requests for pre-authorization before or after regular business hours and/or failure to submit the required documentation could result in a delay in receiving a final determination of **your** request.

14. **REQUIREMENTS FOR OTHER INJURIES**

a) For injuries *other than* the **identified injuries** outlined in paragraph one or the services and/or conditions for treatment, diagnostic testing, or durable medical equipment set forth in paragraph four above, **we** must be provided with written support establishing the need for further treatment before reimbursement may be considered. This documentation is required if medical treatment is necessary beyond the first twenty-eight (28) days following the accident. **We** encourage the submission of comprehensive treatment plans for all injuries to avoid periodic reviews when continued treatment is considered medically necessary for an extended period of time. If a comprehensive treatment plan has not been submitted and approved, notification is required every twenty-eight (28) days following the date of the accident for as long as continued treatment is necessary if coverage is sought. As long as the treatment, diagnostic testing, and/or durable medical equipment rendered/supplied is consistent with the approved treatment plan, additional notification every twenty-eight (28) days following the accident is not required. Once a treatment plan has been approved, the **insured person** must notify **us** in writing of the medical necessity of any treatment, diagnostic testing, or durable medical equipment that varies from the approved treatment plan before reimbursement will be considered.

b) Failure to provide the notification required in this section may result in a co-payment penalty on eligible medical charges of twenty-five percent (25%) if notice is received thirty (30) or more days after the accident or fifty percent (50%) when received sixty (60) or more days after the accident even if services are determined to be medically necessary. Penalties will cease to apply once notification as outlined in this section is received.

15. **VOLUNTARY PROVIDER NETWORK**—In accordance with N.J.A.C. 11:3-4.8 this plan includes a voluntary network for:

- a) Magnetic Resonance Imagery;
- b) Computer Assisted Tomography;
- c) Electrodiagnostic testing listed in N.J.A.C. 11:3-4.5(b)1-3 (except for needle EMGs, H-reflex and nerve conduction velocity (NCV) when performed together by the treating physician);
- d) prescription drugs;
- e) services, equipment or accommodations provided by an ambulatory surgery facility; and



- f) durable medical goods greater than \$50.00 charged or billed amount or rental over thirty (30) calendar days.

Please visit **our** website at [www.progressive.com/claims/providernetworks/](http://www.progressive.com/claims/providernetworks/) for the most up-to-date information on available networks, or contact **your** PIP claims representative. Those individuals who choose not to utilize these networks will be assessed an additional co-payment of thirty percent (30%) of the eligible charge. That co-payment will be the responsibility of the **insured person**.

In addition, for testing, services, and supplies not identified above, **we** make available preferred provider organizations (PPO) that include hospitals, outpatient and urgent care facilities, and all other specialties. The use of a provider for these services is strictly voluntary and is provided as a service to **insured persons**. A co-payment penalty will not be applied if **you** choose to select a provider outside this preferred provider network for these services. Please visit **our** website at [www.progressive.com/claims/providernetworks/](http://www.progressive.com/claims/providernetworks/) for the most up-to-date information on available networks, or contact **your** PIP claims representative.

- 16. **Application of co-payments and deductibles**—In accordance with N.J.A.C. 11:3-4.4(h), co-payments and deductibles will be applied in the following order:
  - a) If applicable, co-payment penalty described in N.J.A.C. 11:3-4.4 (e) and (g);
  - b) Insured deductible as described in N.J.A.C. 11:3-4.4 (a) and (b);
  - c) Insured co-payment as described in N.J.A.C. 11:3-4.4 (a).

## 17. **APPEALS PROCESS**

### **Pre-Service Appeals**

If **you** or an **insured person** disagree with **our** determination with respect to a **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, a written request for appeal must be submitted on the PIP Pre-Service Appeal form by the physician making the initial determination or in his/her absence, another designated physician, through **our** internal Appeals Process within thirty (30) days of receipt of a written denial or modification. A submission based on additional medical information that is supplied more than thirty (30) days after the initial request will be considered a new request for **decision point review** or **precertification** and not an appeal. Submission of information identical to the initial material submitted in support of the request shall not be accepted as a request for appeal. Provided that additional necessary medical information has been submitted, a response to the appeal request shall be made within fourteen (14) days. If it is determined that peer review or an Independent Medical Examination is appropriate, this information will be communicated within ten (10) business days. All requests for pre-service appeals must include, as the

cover page, a fully completed PIP Pre-Service Appeal form, which is available at <http://www.state.nj.us/dobi/pipinfo/aicrapg.htm#protocol>. Request for pre-service appeals under this paragraph must be submitted to **us** on a completed Pre-Service Appeal form by fax at **877-213-7258**. **We** will neither accept nor respond to pre-service appeals that are sent to any other physical address, fax number, or email address. Only requests for pre-service appeals under this paragraph will be accepted at this fax number. Do not submit any other type of correspondence or request to this fax number.

## Post-Service Appeals

As a condition precedent to filing arbitration or litigation, a provider who has accepted an assignment, or any **insured person**, must submit a PIP Post-Service Appeal form to appeal any and all disputes subsequent to the performance or issuance of services, including, but not limited to, any claims for unpaid medical bills for medical expenses and for unpaid services not authorized and/or denied in the **decision point review** and **precertification** process. The request must specify the issue(s) contested and provide supporting documentation. In order to be considered valid, a post-service appeal under this section must be submitted within 90 (ninety) days of service of the adverse decision and at least forty-five (45) days prior to initiating arbitration or litigation. A response to the post-service appeal request shall be made not later than thirty (30) days after receipt of the appeal and all supporting documentation. In addition, all requests for post-service appeal must include, as the cover page, a fully completed PIP Post-Service Appeal form, which is available at <http://www.state.nj.us/dobi/pipinfo/aicrapg.htm#protocol>. The PIP Post-Service Appeal form must be faxed to **us** at **877-213-7258**. **We** will neither accept nor respond to post-service appeals that are sent to any other physical address, fax number, or email address. Only requests for post-service appeals under this paragraph will be accepted at this fax number. Do not submit any other type of correspondence or request to this fax number.

In accordance with and subject to the requirements of N.J.A.C. 11:3-4.7(B)(b), **we** will require only one appeal for each issue appealed.

If the **insured person** or a **health care provider** retains counsel to represent them during the Appeals Process, they do so strictly at their own expense. **We** will not reimburse for counsel fees or any other costs, regardless of the outcome of the appeal.

## 18. DISPUTE RESOLUTION PROCESS

Any disputes not resolved in the Appeals Process must be submitted through the Personal Injury Protection Dispute Resolution process governed by regulations promulgated by the New Jersey Department of Banking and Insurance (N.J.A.C.

11:3-5). **We** retain the right to file a motion to remove any Superior Court action to the Personal Injury Protection Dispute Resolution Process pursuant to N.J.S.A. 39:6A-5.1. Unless emergent relief is sought, failure to utilize the Appeals Process and submit a valid appeal at least forty-five (45) days prior to filing arbitration or litigation will invalidate an assignment of benefits.

## 19. ASSIGNMENT OF BENEFITS

Benefits under this policy part are not assignable except to a **health care provider** for medical expenses representing covered services and/or supplies furnished by the **health care provider** to an **insured person**.

In order for any assignment of benefits to be valid, the **health care provider** must agree, in writing as part of the assignment, to comply fully with **our** Decision Point Review Plan, all **precertification** requirements, and all the terms and conditions of the policy. An assignment that does not explicitly contain such an agreement is invalid.

The **health care provider** must also agree, in writing as part of the assignment, to hold harmless the **insured person** and **us** for any reduction in benefits caused by the **health care provider's** failure to fully comply with the terms of **our** Decision Point Review Plan, all **precertification** requirements, or the terms and conditions of the policy.

Any and all assignments of benefits by an **insured person** to a **health care provider** shall become void and unenforceable under the following conditions:

- a) coverage is not afforded under the policy;
- b) a **health care provider** does not comply with all the requirements, duties, and conditions of the policy, including but not limited to all duties of cooperation listed in Part VI of the policy—Duties In Case of an Accident or Loss;
- c) a **health care provider** of services and/or supplies does not submit to an Examination Under Oath when **we** request same; which **we** may conduct outside of the presence of the **insured person(s)** or any other person(s) seeking coverage, and answer all reasonable questions **we** may ask as often as **we** may reasonably require;
- d) a **health care provider** of services and/or supplies does not comply with all requests for medical records or test results; or
- e) a **health care provider** does not comply with the "Dispute Resolution" provisions in **our** policy and in **our** approved Decision Point Review Plan, including utilization of the Appeals Process.

## 20. TESTS FOR WHICH THE LAW PROHIBITS COVERAGE UNDER ANY CIRCUMSTANCES

In accordance with N.J.A.C. 11:3-4.5(a), **we** will not provide re-

imbursement for the following diagnostic tests, which have been determined to 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:

- a) Spinal diagnostic ultrasound;
- b) Iridology;
- c) Reflexology;
- d) Surrogate arm mentoring;
- e) Surface electromyography (surface EMG);
- f) Mandibular tracking and stimulation; and
- g) Any other diagnostic test that is determined by New Jersey law or regulation to be ineligible for Personal Injury Protection coverage.

21. **OTHER NON-REIMBURSABLE TESTS**—In accordance with N.J.A.C. 11:3-4.5(f) and 13:30-8:22 (c), **we** 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):

- a) Mandibular tracking;
- b) Surface EMG;
- c) Sonography;
- d) Doppler ultrasound;
- e) Needle EMG;
- f) Electroencephalogram;
- g) Thermograms/thermographs;
- h) Videofluoroscopy; and
- i) Reflexology