

**HOOVER REHABILITATION
SERVICES, INC.**

**DECISION POINT REVIEW
AND PRECERTIFICATION
PROGRAM MATERIALS AND
FORMS
N.J.A.C. 11:3-4 ET SEQ.**



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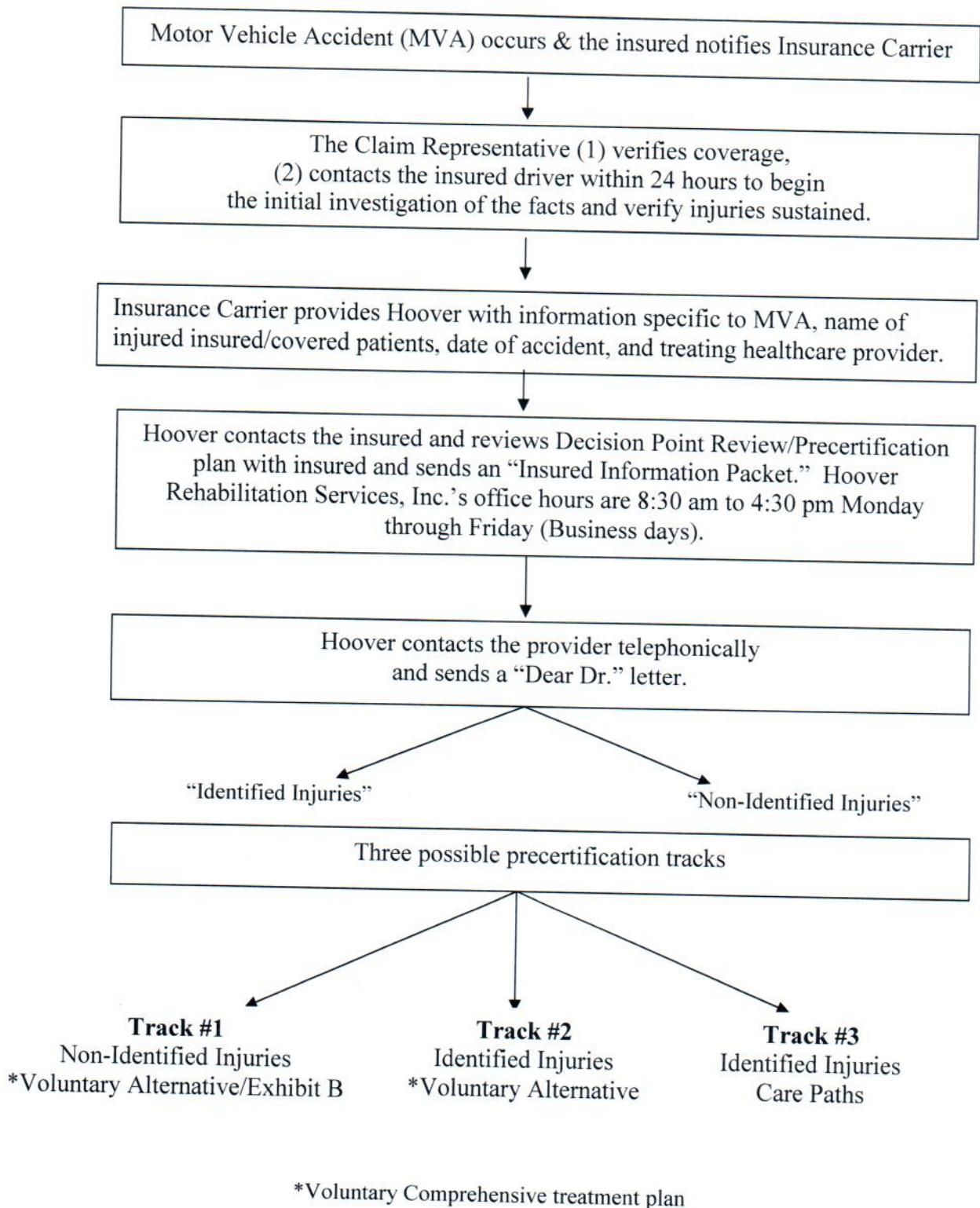
HOOVER REHABILITATION SERVICES, INC.

Decision Point Review and Pre-certification Program Materials and Forms

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**Flow Chart of Precertification & Decision Point Review Protocols
HOOVER REHABILITATION SERVICES, INC.
(In compliance with N.J.A.C. 11:3-4, et seq., as amended)**



TRACK # 1

Non-Identified Injuries (EXHIBIT A)

Providers shall be requested to obtain precertification of the services itemized in EXHIBIT B. Additionally, Hoover will work in conjunction with the provider to obtain and certify a mutually agreeable course of treatment, which will include itemized services and a defined treatment period. A comprehensive treatment plan (**Tx Plan**) is voluntary, but precertification of services in EXHIBIT B is mandatory.

Nationally accepted criteria will be utilized by Hoover to facilitate the precertification and utilization review process. Hoover's Medical Director may refer the case to one of the board-certified medical specialists on its Medical Advisory Board (**MAB**).

The precertification process will proceed in accordance with Insurance Carrier's policy. Throughout the course of the patient's care, requests for additional services will require precertification.

Patient Improved
Discharge

If patient's condition does not resolve, the case may be referred for case management, independent medical examination (IME), or revision of the treatment plan.

For patients who are admitted to inpatient facilities on an emergency basis, Hoover will initiate concurrent utilization review for continued hospital confinement, starting on the eleventh (11) day following the MVA.

A 30% co-pay (\$10 for prescription drugs) will be waived if the insured voluntarily utilizes a conveniently located network facility for medically necessary diagnostic tests as specified in NJAC 11:3 - 4.8(b), durable medical equipment and/or prescriptions. Hoover Rehabilitation Services, Inc. is contracted with ALTA SERVICES, LLC, dba CHN solutions for voluntary network services. Information regarding the availability of network providers can be found at <http://www.chnnetwork.com/volnets/>.

TRACK # 2

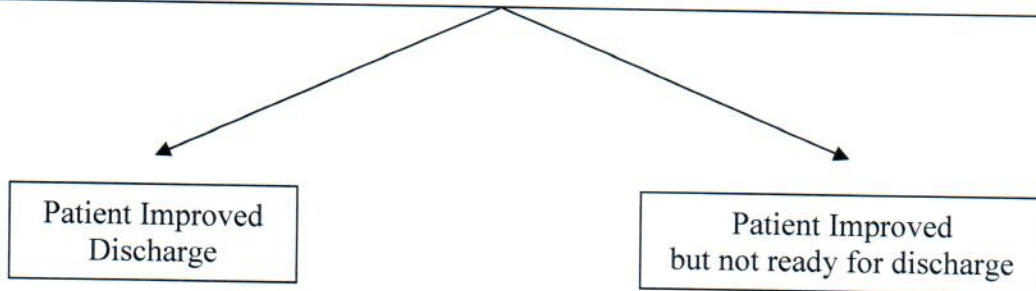
Identified Injuries – Voluntary Precertification Alternative (EXHIBIT A)

Provider shall be requested to submit a treatment plan (**Tx Plan**) for Decision Point Review/Precertification review. Hoover will work in conjunction with the provider to obtain and certify a mutually agreeable Tx Plan, which will include itemized services and a defined treatment period.

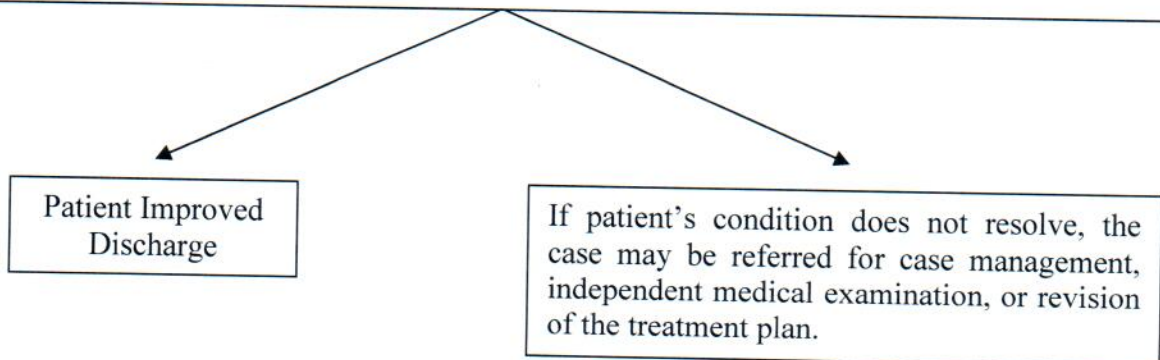
Nationally accepted criteria, in conjunction with N.J.A.C 11:3-4, et seq., as amended, Care Paths (**CARE PATHS**) will be utilized by Hoover to facilitate the Decision Point Review/Precertification and utilization review process. Hoover's Medical Director may refer the case to one of the board-certified medical specialists on its Medical Advisory Board (**MAB**). The Decision Point Review/Precertification process will proceed in accordance with the carrier's policy.

In consideration of his/her participation in the Voluntary Precertification process, the provider will be advised that if his/her submitted bills are consistent with the precertified services, the bills will be paid without review or audit.

Insured patients will not be responsible for penalty co-payments for medical services described in the certified Tx Plans, throughout the plan's duration, when providers opt for the Voluntary Precertification alternative.



If additional services are required (i.e., not previously approved with the Tx Plan), or the proposed duration of care will extend beyond the end of the previously defined treatment period, additional precertification will be necessary. No penalties will be assessed if the provider continues to participate in the Voluntary Precertification process.



TRACK # 3

Identified Injuries – Care Path/Precertification Alternative

Treating Provider opts not to participate in the Voluntary Precertification Alternative, and does not submit a treatment plan during the first four (4) weeks following the MVA; for Identified Injuries (EXHIBIT A)

In regard to N.J.A.C. 11:3-4, et seq., as amended:

- All services that deviate from the Care Path protocols require prior authorization. If the provider fails to precertify such services, the insured/patient may be responsible for a **50% co-payment**, even if the services are considered to be medically necessary.
- Failure of the provider to request Decision Point Review at Decision Points on the Care Paths will result in a **50% co-payment** on behalf of the insured, even if the services are considered to be medically necessary.
- Diagnostic testing services (EXHIBIT B) shall require decision point review after the 10th day following the MVA. Failure to obtain prior authorization for diagnostic testing services may result in a penalty to the insured, consistent with the insurance policy.
- If Hoover has NOT received a Tx Plan or request for precertification of services from the provider, on the 30th day following the MVA, Hoover will inform the Insurance Carrier of the non-receipt of this information.

If Hoover receives no further communication from the provider, or request for precertification of services, Hoover will:

- Issue a letter of non-compliance to the claimant with a copy to the treating provider and attorney.
- If no response to non-compliance letter within 30 days, Hoover will close the case.

If Hoover receives a request for precertification of services or a Tx Plan, on or subsequent to the 28th day following the MVA:

- In addition to nationally accepted criteria and the MAC, Hoover will utilize the Care Paths as the treatment guidelines to facilitate the precertification process.
- Decision Review Points will be adhered to closely.
- Bills for services previously performed will be subject to review for medical necessity and audit prior to payment. Care Path guidelines will be referenced throughout the auditing process.
- Bills for services that deviate from the Care Paths will be subject to review for medical necessity and audit prior to payment. Care Path guidelines will be referenced throughout the auditing process
- Non-certified services, regardless of medical necessity, may be subject to a 50% co-payment.

Hoover Rehabilitation Services, Inc.
C/O **(Insurance Co.)**
 (Address)
 (Address)

EXHIBIT A

Identified Injuries

M50	Displacement of cervical intervertebral disc without myelopathy
M51	Displacement of lumbar intervertebral disc without myelopathy
M51.24	Displacement of thoracic intervertebral disc without myelopathy
M51.9	Displacement of intervertebral disc, site unspecified, without myelopathy
M51.9	Intervertebral disc disorder with myelopathy, unspecified region
M50.00	Intervertebral disc disorder with myelopathy, cervical region
M51	Intervertebral disc disorder with myelopathy, thoracic region
M51.06	Intervertebral disc disorder with myelopathy, lumbar region
M60	Disorders of muscle, ligament and fascia
M62	Spasm of muscle
M99	Non-allopathic lesions-not elsewhere classified
M99.01	Somatic dysfunction of cervical region
M99.02	Somatic dysfunction of thoracic region
M99.03	Somatic dysfunction of lumbar region
M99.04	Somatic dysfunction of sacral region
M99.08	Somatic dysfunction of rib cage
S33	Sprains and strains of sacroiliac region
S33	Sprains and strains of lumbosacral (joint)(ligament)
S33	Sprains and strains of sacrospinatus (ligament)
S33	Sprains and strains of sacrotuberous region
S33	Sprains and strains of other specified sites of sacroiliac region
S33	Sprains and strains, unspecified site of sacroiliac region
S13, S16	Sprains and strains of neck
S23	Sprains and strains, thoracic
S33	Sprains and strains, lumbar
S33	Sprains and strains, sacrum
S33	Sprains and strains, coccyx
S13, S23, S33	Sprains and strains of back, unspecified site
S30	Contusion of back
S30	Contusion of back, excludes interscapular region
S20	Contusion of back, interscapular region
S14	Injury to cervical root
S34	Injury to lumbar root
S34	Injury to sacral root

Hoover Rehabilitation Services, Inc.
C/O (Insurance Co)
(Address)
(Address)

EXHIBIT B

Diagnostic Tests that are subject to Decision Point Review (all diagnosis)

1. Brain audio evoked potentials (BAEP),
2. Brain evoked potentials (BEP),
3. Computer assisted tomograms (CT, CAT scan),
4. Dynatron/cybex station/cybex studies,
5. Electroencephalogram (EEG),
6. H-reflex studies,
7. Magnetic resonance imaging (MRI),
8. Needle electromyography (EMG),
9. Nerve conduction velocity (NCV),
10. Somatosensory evoked potential (SSEP),
11. Sonogram/ultrasound,
12. Videofluoroscopy,
13. Visual evoked potential (VEP)
14. Brain Mapping
15. Thermography and Thermograms

Services that require Precertification

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

EXHIBIT C

Reconsideration Process HOOVER REHABILITATION SERVICES, INC.

1. When Hoover is unable to certify, or renders a determination not to certify an admission, hospital stay, treatment plan, diagnostic test, or other service the attending or ordering provider:
 - Will be notified by telephone of the determination within 3 business days (Monday through Friday 8:30 am to 4:30 pm), which will be confirmed in writing. Requests received after 4:30 pm on a normal business day, will be considered received on the next normal business day, excluding Federal or New Jersey holidays. Requests received after 4:30 pm on Friday will be considered received on Monday at 8:30 am.
 - May request the clinical criteria utilized to make the determination,
 - Will have the opportunity to request reconsideration by the physician advisor who made the initial determination.

2. Reconsideration will fall into 1 of 2 categories: **Pre-Service Appeals** or **Post-Service Appeals**.
 - a.) **Pre-Service Appeal:** 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"). A pre-service appeal shall be submitted on the official Pre-Service Appeal form no later than 30 days after receipt of a written denial or modification of requested services. The provider will submit a Pre-Service Appeal form, along with the medical rationale to support the appeal via fax to 570-283-1637. *The medical rationale should include new information to support the appeal and should not just be the same as the prior Precertification request.* Hoover will respond to the Pre-Service Appeal within 14 business days. There is only one level of appeal for any issue. The Pre-Service Appeal form is available on the NJ DOBI website at http://www.state.nj.us/dobi/pipinfo/preserviceappeal_170208.pdf, but is also provided to claimant, attorney, and provider with DPR notifications (Dear Dr. and Dear Claimant letters).
 - b.) **Post-Service Appeal:** Appeals subsequent to the performance or issuance of the services. A post-service appeal shall 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. The provider will submit a Post-Service Appeal form, along with the medical rationale to support the appeal via fax to 570-283-1637. *The medical rationale should include new information to support the appeal and should not be the same as the prior Precertification request.* The Post-Service Appeal form is available on the NJ DOBI website at http://www.state.nj.us/dobi/pipinfo/postserviceappeal_170208.pdf, but is also provided to claimant, attorney, and provider with DPR notifications (Dear Dr. and Dear Claimant letters). Hoover will forward this appeal to either the Repricing Department (if it is a fee schedule/repricing issue), or to the Insurance adjuster handling the claim (if it is a copayment/deductible or other claims issue). The Post-Service Appeal will be responded to within 30 calendar days. There is only one level of appeal for any issue.

3. When, during the course of generating a review determination, it becomes necessary for the Hoover Physician Advisor to refer the case to a specialist-consultant on Hoover's Medical Advisory Board, the specialist-consultant (or one of like specialty) will be available to participate in the reconsideration process.

Provider Appeal Process

When reconsideration does not resolve a difference of opinion, the attending or ordering provider may submit the case for appeal through the Personal Injury Protection Dispute Resolution process.

Hoover will inform the physician or other ordering provider of their right to initiate an appeal and the procedure to do so when the review determination has been made. To make a demand for PIP alternate dispute resolution in accordance with N.J.A.C. 11:3-5, you may contact Forthright at 732-271-6100. Forms, rules and procedures are available on the web at <http://www.state.nj.us/dobi/pipinfo/aicrapg.htm#dispute> .

NEW JERSEY PIP PRE-SERVICE APPEAL FORM

TYPE OR PRINT LEGIBLY AND KEEP WITHIN THE LINES OF THE SPACE PROVIDED	1. DATE APPEAL SUBMITTED	2. RECEIPT DATE OF ADVERSE DECISION
---	--------------------------	-------------------------------------

CLAIM INFORMATION

3. INSURANCE COMPANY	4. CLAIM #	5. DATE OF LOSS
----------------------	------------	-----------------

PATIENT INFORMATION

6. LAST NAME	7. FIRST NAME	8. MIDDLE INITIAL	9. DATE OF BIRTH
10. ADDRESS (No. Street)	11. CITY	12. STATE	13. ZIP

PROVIDER/FACILITY INFORMATION

14. LAST NAME	15. FIRST NAME	16. FACILITY-OFFICE NAME								
17. SPECIALTY	18. TAX ID #	19. NPI #								
20. ADDRESS (No. Street)	21. CITY	22. STATE	23. ZIP							
24. TELEPHONE # (Include Area Code)	25. FAX # (Include Area Code)	26. EMAIL ADDRESS								
27. PROVIDER AVAILABILITY DAYS OF WEEK: <table style="width: 100%; text-align: center; font-size: small;"> <tr> <td style="width: 12.5%;">MONDAY</td> <td style="width: 12.5%;">TUESDAY</td> <td style="width: 12.5%;">WEDNESDAY</td> <td style="width: 12.5%;">THURSDAY</td> <td style="width: 12.5%;">FRIDAY</td> </tr> </table>		MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	28. PROVIDER AVAILABILITY TIME OF DAY: <table style="width: 100%; text-align: center; font-size: small;"> <tr> <td style="width: 40%;">FROM</td> <td style="width: 20%;">TO</td> </tr> </table>		FROM	TO
MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY						
FROM	TO									

DOCUMENTS INCLUDED

29. CHECK THOSE APPLICABLE BELOW (Include Proof of Receipt if Applicable)

<input type="checkbox"/> *ORIGINAL APTP FORM	<input type="checkbox"/> *APTP DECISION/RESPONSE DOCUMENT	<input type="checkbox"/> *APPEAL RATIONALE NARRATIVE
<input type="checkbox"/> INDEPENDENT MEDICAL EXAM REPORT	<input type="checkbox"/> DIAGNOSTIC REPORT(S)	<input type="checkbox"/> PEER REVIEW REPORT
<input type="checkbox"/> OTHER SUPPORTING DOCUMENTS (Describe): _____		

PRE-SERVICE APPEAL ISSUES

30. DATE(S) OF REQUEST						31. CPT, HCPCS, NDC	32. RESPONSE NOT RECEIVED WITHIN 3 BUSINESS DAYS YES INDICATE WITH X	33. ADMINISTRATIVE DISPUTE YES INDICATE WITH X	34. MEDICAL NECESSITY DISPUTE YES INDICATE WITH X
FROM			TO						
MM	DD	YY	MM	DD	YY				

* Indicates minimum documents required that must be included with the submission of this form with ADDITIONAL/NEW supporting records only

FRAUD PREVENTION-NEW JERSEY WARNING

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

PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED OR REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

7a

35. SIGNATURE OF PROVIDER _____

36. DATE

NEW JERSEY PIP POST-SERVICE APPEAL FORM

TYPE OR PRINT LEGIBLY AND KEEP WITHIN THE LINES OF THE SPACE PROVIDED	1. DATE APPEAL SUBMITTED	2. RECEIPT DATE OF ADVERSE DECISION
---	--------------------------	-------------------------------------

CLAIM INFORMATION

3. INSURANCE COMPANY	4. CLAIM #	5. DATE OF LOSS
----------------------	------------	-----------------

PATIENT INFORMATION

6. LAST NAME	7. FIRST NAME	8. MIDDLE INITIAL	9. DATE OF BIRTH
10. ADDRESS (No. Street)	11. CITY	12. STATE	13. ZIP

PROVIDER/FACILITY INFORMATION

14. LAST NAME	15. FIRST NAME	16. FACILITY-OFFICE NAME	
17. SPECIALTY	18. TAX ID #	19. NPI #	
20. ADDRESS (No. Street)	21. CITY	22. STATE	23. ZIP
24. TELEPHONE # (Include Area Code)	25. FAX # (Include Area Code)	26. EMAIL ADDRESS	

27. PROVIDER AVAILABILITY DAYS OF WEEK:					28. PROVIDER AVAILABILITY TIME OF DAY:	
MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	FROM	TO

DOCUMENTS INCLUDED

29. CHECK THOSE APPLICABLE BELOW (Include Proof of Receipt if Applicable)

<input type="checkbox"/> *ORIGINAL BILL (HCFA/UB)	<input type="checkbox"/> *EXPLANATION OF BENEFIT/PAYMENT	<input type="checkbox"/> *APPEAL RATIONALE NARRATIVE
<input type="checkbox"/> APTP DECISION/RESPONSE	<input type="checkbox"/> INDEPENDENT MEDICAL EXAM REPORT	<input type="checkbox"/> PEER REVIEW REPORT
<input type="checkbox"/> AUDIT REPORT	<input type="checkbox"/> NETWORK TERMINATION DOCUMENT	<input type="checkbox"/> PPO CONTRACT
<input type="checkbox"/> OTHER SUPPORTING DOCUMENTS (Describe): _____		

POST-SERVICE APPEAL ISSUES

30. EOB ID	31. TOTAL BILL REIMBURSEMENT	32. EXPECTED BILL REIMBURSEMENT	33. **BILL LEVEL APPEAL CODE(S) 1-10

34. DATE(S) OF SERVICE						35. CPT, HCPCS, NDC	36. LINE LEVEL REIMBURSE AMOUNT	37. LINE LEVEL EXPECTED REIMBURSE AMOUNT	38. **LINE LEVEL APPEAL CODE(S) A-S
FROM			TO						
MM	DD	YY	MM	DD	YY				

* Indicates minimum documents required that must be included with the submission of this form with **ADDITIONAL/NEW** supporting records only
 ** Indicates sections that should be completed using the letter(s)/number(s) that correspond to the reason codes on the back of this form

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PROVIDER STATEMENT
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7b

39. SIGNATURE OF PROVIDER _____

40. DATE _____

NEW JERSEY PIP POST-SERVICE APPEAL

REASON CODES

BILL LEVEL APPEAL CODES		LINE LEVEL APPEAL CODES	
1	Improper Deductible Applied	A	Improper Application of Fee Schedule Amount
2	Improper Co-pay Applied	B	Improper Application of Modifier Reduction
3	Improper Interest Applied	C	Improper Application of Multiple Reduction Calculation
4	Interest Due - Payment Not Made Timely	D	Improper Application of Daily Max Cap Calculation
5	Bill Processed Under Wrong Patient	E	Improper use of National Correct Coding (NCCI)
6	No Response To Bill Submitted Post 60 Days	F	Improper Application of U&C Amount
7	Improper Application of Coordination of Benefits	G	Improper Application of PPO Amount
8	Improper Use of PPO - Not Participating In Network	H	Improper Application of Pre-cert Penalty Co-pay
9	Improper Use of PPO - Terminated From Network	I	Improper Application of Voluntary Network Penalty Co-pay
10	Improper Denial Based on Coverage Investigation	J	Improper Application of Prospective Medical Necessity Denial
		K	Improper Application of Retrospective Medical Necessity Denial
		L	Improper Application of Bill Audit Reduction
		M	Improper Application of Medical Code Review Reduction
		N	Improper Application of Peer Review Reduction
		O	Improper Application of IME Reduction
		P	Improper Application of Missing Supportive Medical Records Denial
		Q	Improper Application of Coordination of Benefits
		R	Data Capture Error Caused Improper Reimbursement
		S	No Response to Services Billed

EXHIBIT D

(Insurance Company): Assignment of Benefits

Payment of Benefits

1. The Insurance Company may, at their option, pay any medical expense benefits or essential services benefits to the:

- a. "Insured," or
- b. Person or organization providing products or services for such benefits.

These benefits shall not be assignable except to providers of service benefits. Any attempt to assign benefits to a party who is not a provider of service benefits shall be null and void and shall not be honored. If so assigned, all requirements, duties and conditions of the Policy, including but not limited to Precertification, Decision Point Reviews, exclusions, deductibles, co-payments and duties of cooperation following an accident or loss, shall remain in effect. If a valid assignment is made by an Insured and accepted by the provider of the assigned service benefits, the provider shall 1) agree to be subject to the requirements of our Decision Point Review /Precertification Plan, 2) indemnify and hold harmless the Insured against any penalty co-payments caused by the provider's failure to comply with the terms of our Decision Point Review/Precertification Plan and 3) submit any dispute to alternate dispute resolution.

ATTENDING PROVIDER TREATMENT PLAN

 INITIAL SUBMISSION

 FOLLOW-UP SUBMISSION

DATE SUBMITTED

TYPE OR PRINT LEGIBLY				CLAIM #:			Month	Day	Year					
PATIENT INFORMATION						POLICYHOLDER INFORMATION (if different)								
1. PATIENT'S NAME Last _____ First _____ Initial _____			11. DATE OF ACCIDENT _____			14. POLICYHOLDER'S NAME Last _____ First _____ Initial _____								
2. PATIENT'S ADDRESS (No. Street) _____			12. IS PATIENT'S CONDITION RELATED TO: A. EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO B. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO C. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			15. POLICYHOLDER'S ADDRESS (No. Street) _____								
3. CITY _____		4. STATE _____		16. CITY _____			17. STATE _____							
5. ZIP CODE _____		6. TELEPHONE # (Include Area Code) _____		18. TELEPHONE # (Include Area Code) _____			19. ZIP CODE _____							
7. PATIENT BIRTHDATE _____		8. SEX <input type="checkbox"/> M <input type="checkbox"/> F		13. IS PATIENT UNABLE TO WORK? <input type="checkbox"/> NO <input type="checkbox"/> YES			20. RELATIONSHIP TO PATIENT _____							
9. INSURANCE COMPANY _____			10. POLICY NUMBER _____											
PROVIDER INFORMATION														
21. NAME OF TREATING PROVIDER Last _____ First _____ Initial _____			22. TAX I.D. _____		23. NPI _____	24. SPECIALTY _____		25. FACILITY OR OFFICE NAME _____						
26. FACILITY /OFFICE ADDRESS (No. Street) _____					27. CITY _____		28. STATE _____	29. ZIP CODE _____						
30. TELEPHONE # (Include Area Code) _____		31. EMAIL ADDRESS _____			32. FAX # (Include Area Code) _____		33. INITIAL DATE OF TX _____	34. DATE OF LAST VISIT _____						
35. PATIENT MEDICAL HISTORY. HAS PATIENT EVER HAD ANY OF THE FOLLOWING SERVICES? CHECKMARK THOSE APPLICABLE BELOW. (*NOTE-ALL BOXES CHECKED REQUIRE A BRIEF DESCRIPTION OF SERVICE AND DATE PROVIDED ON SEPARATE ATTACHMENT) <input type="checkbox"/> MEDICATIONS <input type="checkbox"/> MRI <input type="checkbox"/> SURGERY <input type="checkbox"/> X-RAY <input type="checkbox"/> DIAGNOSTIC TEST <input type="checkbox"/> EXISTING CONDITIONS <input type="checkbox"/> COMORBIDITIES <input type="checkbox"/> OTHER														
36. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below using Diagnosis Pointer in section 38 below)							ICD Ind. <input type="checkbox"/> 9 <input type="checkbox"/> 10							
A. _____	B. _____		C. _____		D. _____		E. _____	F. _____						
G. _____	H. _____	I. _____	J. _____	K. _____	L. _____									
37. CHECK APPROPRIATE CARE PATH (if applicable) <input type="checkbox"/> CP1 <input type="checkbox"/> CP2 <input type="checkbox"/> CP3 <input type="checkbox"/> CP4 <input type="checkbox"/> CP5 <input type="checkbox"/> CP6														
PROPOSED COURSE OF TREATMENT AS IT RELATES TO THIS MVA														
38. DATE(S) OF REQUEST FROM _____ TO _____						PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances)								
MM DD YY MM DD YY						CPT/HCPCS		EQUIPMENT Purchase: Rental	SPINAL INJECTION Unilateral: Bilateral	DIAGNOSIS POINTER	FREQUENCY (Times per visit)	FREQUENCY (Visits per week)	DURATION (# of weeks)	TOTAL UNITS

 INCLUDE SUPPORTING DOCUMENTS

FRAUD PREVENTION - NEW JERSEY WARNING

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PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED AND PREVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE OF PROVIDER _____

DATE _____

TREATMENT OF ACCIDENTAL INJURY TO THE SPINE AND BACK - CARE PATHS

EXHIBIT 1 -Glossary of Terms

Acute Disease - a disease with rapid onset and short course to recovery. Not chronic.

Care Path - a recommended extensive course of care based on professionally recognized standards.

Case Management - a method of coordinating the provision of healthcare to persons injured in automobile accidents, with the goal of ensuring continuity and quality of care and cost effective outcomes. The Case Manager may be a nurse, social worker **psychologist**, or physician, preferably with certification in case management.

Cauda Equina - a collection of spinal roots that descend from the lower part of the spinal cord. They exist in the lower part of the vertebral canal.

Chronic Disease - a disease with long duration that changes little and progresses slowly. The opposite of acute.

Clinical Evaluation - the evaluation of the symptoms and signs of an injured person by a treating practitioner.

Conservative Therapy - treatment which is not considered aggressive; avoiding the administration of medicine or utilization of invasive procedures until such procedures are clearly indicated.

Contusion - an injury to underlying soft tissues where the skin is not broken. A bruise.

Diagnostic Evaluation - the process of differentiating between two or more diseases with similar signs and symptoms through the use of evaluative procedures such as imaging, laboratory, and physical tests.

Herniation - the protrusion or projection of an organ or other body structure through a defect or natural opening in a covering membrane, muscle, or bone.

Independent Consultative Opinion - physical examination by a physician of similar specialty to the injured person's treating practitioner to provide a second medical opinion. The independent physician may support, refute, or provide alternatives to the current diagnosis and treatment plans.

Non-Compliant - a patient who willfully chooses not to participate in the treatment plan agreed upon by the patient and his/her healthcare provider and does not have secondary issues such as lack of transportation, pre-existing conditions or comorbidities.

PT - Physical Therapy - the evaluation, assessment, and treatment of dysfunction caused by injuries to the soft tissue and muscles/skeleton . Treatment shall consist of therapeutic exercises, education and other modalities, such as the therapeutic use of heat, light, water, electricity, massage and non-ionizing radiation, and procedures that focus on improving posture, locomotion, strength, endurance, balance coordination, joint mobility, flexibility and an individual's ability to go through the functional activities of daily living (ADLS) and on alleviating pain. PT rendered to persons injured in automobile accidents must be provided by a person whose scope of licensure includes physical therapy.

Radicular - pertaining to a root (such as a nerve root) disorder.

Radiculopathy - a disorder of a nerve root.

Sign - an objective manifestation, usually indicative of a disease or disorder. Signs can be observed by the clinician, as opposed to symptoms which are perceived only by the affected individual.

Soft Tissue Injury - injuries sustained to the muscle, skin, connective tissue.

Spine - the vertebral column.

Spinal Shock - an acute condition resulting from spinal cord severance. Characterized by a total sensory loss and loss of reflexes below the level of injury and flaccid paralysis.

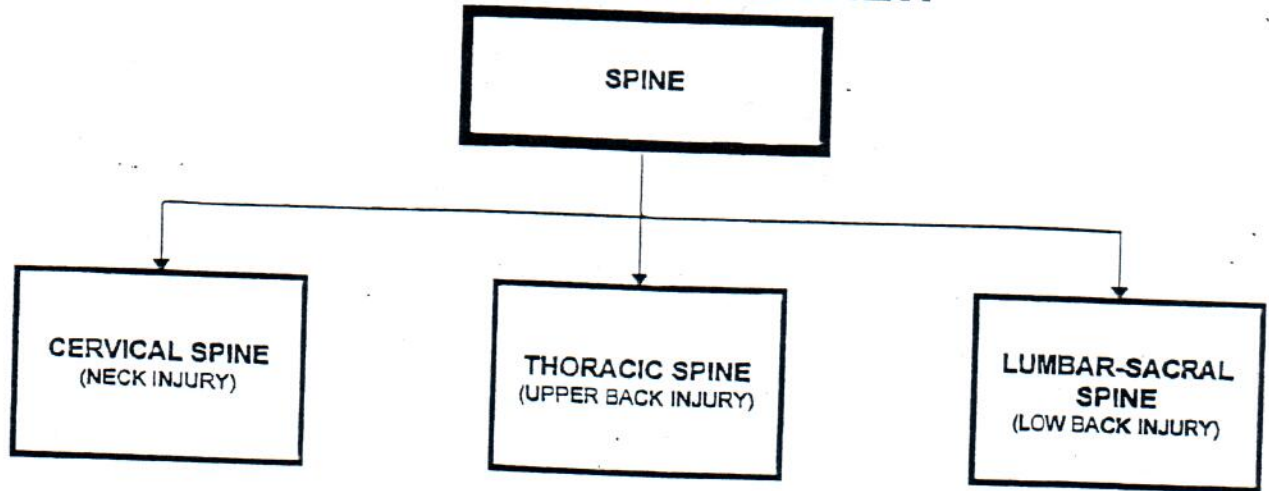
Sprain - an injury at a joint where a ligament is stretched or torn.

Strain - an injury caused by the over-stretching or tearing of a muscle or tendon. In its most severe form, the muscle ruptures.

Symptom - a subjective manifestation, usually indicative of a disease or disorder. Symptoms are experienced only by the affected individual, as opposed to signs which can be observed by others.

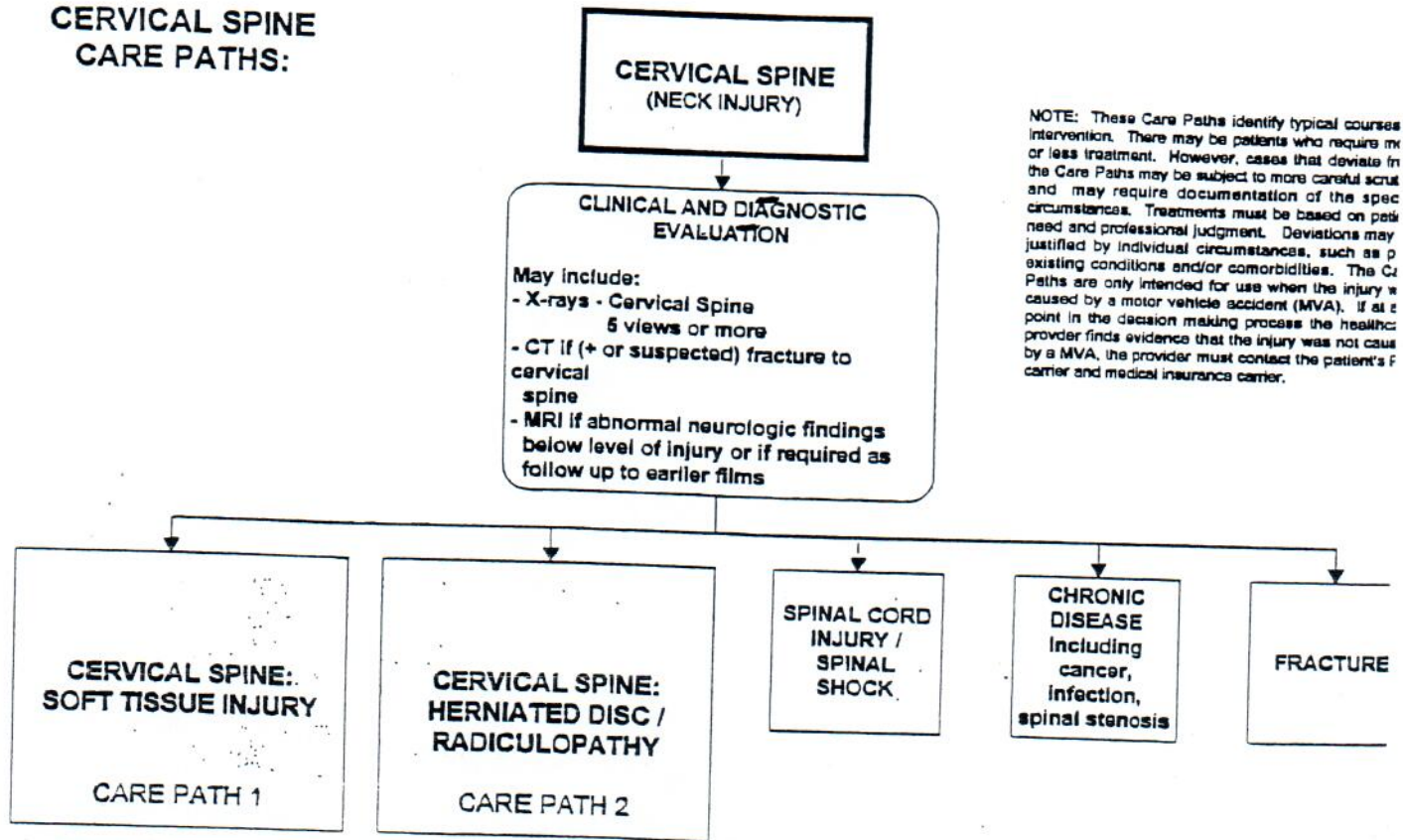
Treatment Plan - specific medical, surgical, chiropractic, acupuncture, or psychiatric and psychological procedures used to improve the signs or symptoms associated with injuries sustained in automobile accidents, e.g., physical therapy, surgery, administration of medications, etc.

TREATMENT OF ACCIDENTAL INJURY TO THE SPINE AND BACK CARE PATH OVERVIEW



The following flow charts address the three anatomical areas of spinal injuries. Care Paths 1 through 6 have been developed for the conditions noted in the shaded boxes.

CERVICAL SPINE CARE PATHS:

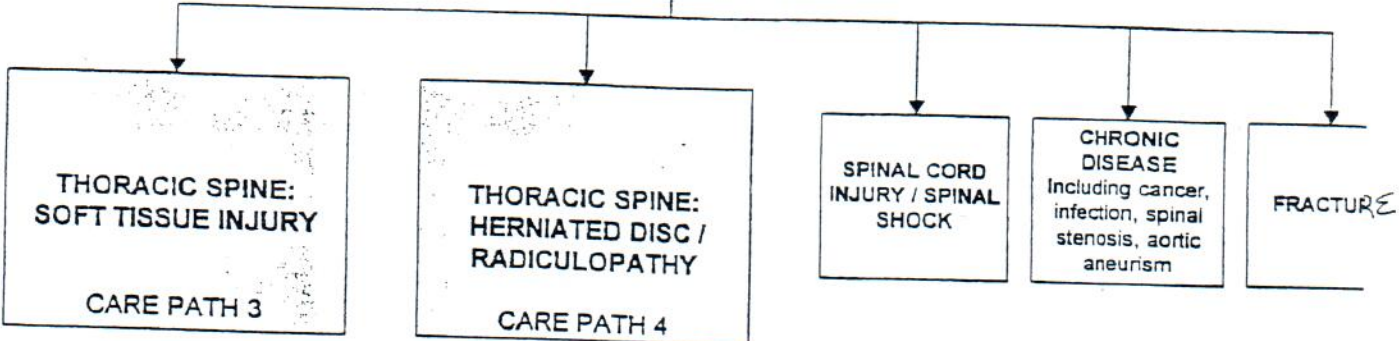


NOTE: These Care Paths identify typical courses of intervention. There may be patients who require more or less treatment. However, cases that deviate from the Care Paths may be subject to more careful scrutiny and may require documentation of the specific circumstances. Treatments must be based on patient need and professional judgment. Deviations may be justified by individual circumstances, such as pre-existing conditions and/or comorbidities. The Care Paths are only intended for use when the injury was caused by a motor vehicle accident (MVA). If at a point in the decision making process the healthcare provider finds evidence that the injury was not caused by a MVA, the provider must contact the patient's insurer and medical insurance carrier.

THORACIC SPINE CARE PATHS:

THORACIC SPINE (UPPER BACK INJURY)

CLINICAL AND DIAGNOSTIC EVALUATION
 May include:
 - X-rays - Thoracic Spine (2-3 views or more)
 - CT if (+ or suspected) fracture to thoracic spine
 - MRI if abnormal neurologic findings or if required as follow up to earlier films



LUMBAR-SACRAL SPINE CARE PATHS:

LUMBAR-SACRAL SPINE (LOW BACK INJURY)

CLINICAL AND DIAGNOSTIC EVALUATION
 May include:
 - X-rays - LS Spine (3 views or more)
 - CT if (+ or suspected) fracture to LS spine
 - MRI if abnormal neurologic findings or if required as follow up to earlier films

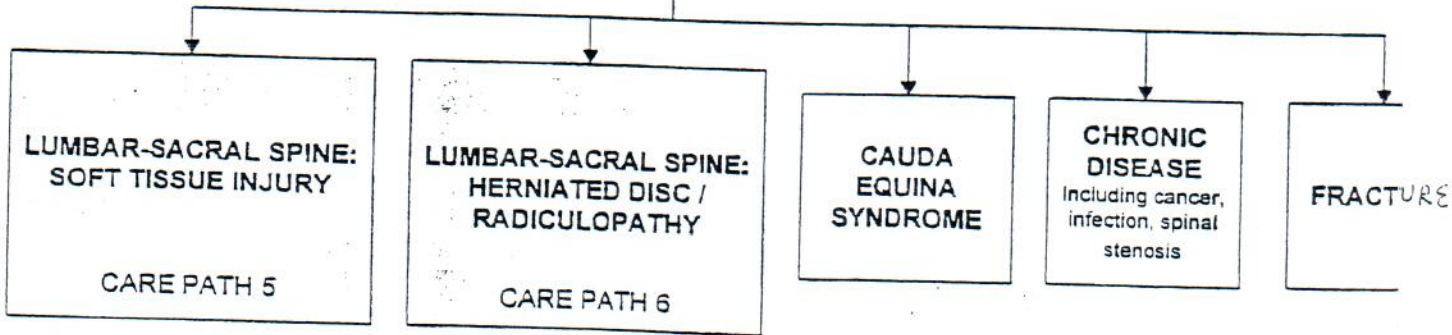


EXHIBIT 3

CARE PATH 1

NOTE: These Care Paths identify typical courses of intervention. There may be patients who require more or less treatment. However, cases that deviate from the Care Paths may be subject to more careful scrutiny and may require documentation of the special circumstances. Treatments must be based on patient need and professional judgment. Deviations may be justified by individual circumstances, such as pre-existing conditions and/or comorbidities. The Care Paths are only intended for use when the injury was caused by a motor vehicle accident (MVA). If at any point in the decision making process the healthcare provider finds evidence that the injury was not caused by a MVA, the provider must contact the patient's PIP carrier and medical insurance carrier.

**CERVICAL SPINE
SOFT TISSUE INJURY
(STRAIN/SPRAIN/CONTUSION WHIPLASH)
OF THE NECK**

**CONSERVATIVE THERAPY
(up to 4 weeks)**

- Provider office visits (up to 5)
- Medications¹
- Consider soft neck collar (maximum 48 hours)
- Increasing exercise
- Consider PT program (2-3 times per week, up to 4 weeks)³
- Spinal manipulation² (1-3 visits per week, up to 4 weeks)

(The total number of visits for physical therapy and spinal manipulation should not exceed 12.)

4 WEEKS POST INJURY

Improvement in symptoms based on objective findings?

YES

NO

Symptoms Resolved

Symptoms Minimally Resolved

Symptoms Worse or Unresolved

Discharge from Care

Patient Compliant with Treatment Plan?

Development of Radiculopathy?

NO

YES

NO

YES

Continue Conservative Therapy

- Begin or continue PT
- Consider Specialist Referral
- Consider Psychosocial Evaluation⁴

Continue Conservative Therapy

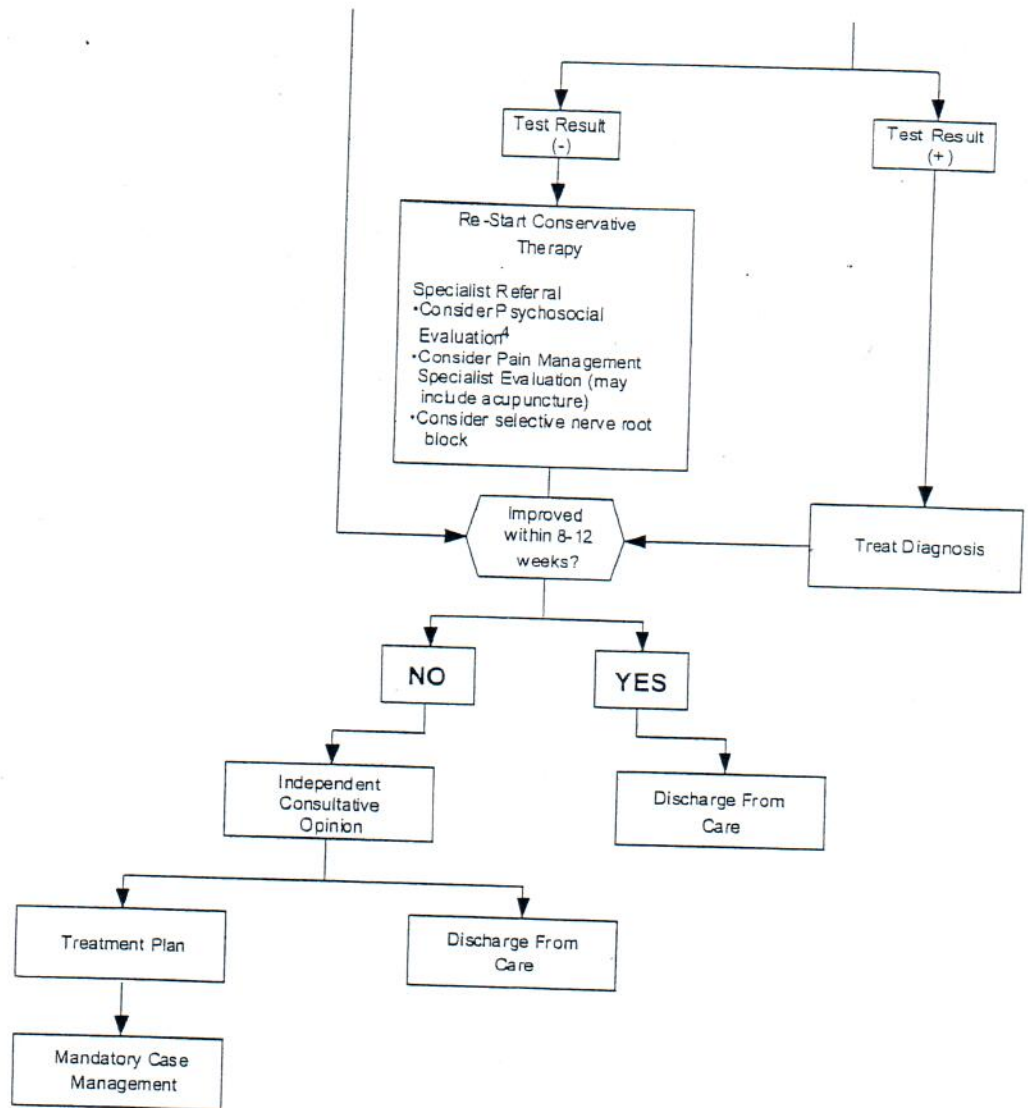
- Begin or continue PT
- Consider Specialist Referral
- Pain Management up to 3 visits (may include acupuncture)

Diagnostic Re-evaluation

May include:

- CBC
- ESR
- X-ray, CT, MRI (if not previously done)
- Bone scan

1, 2, 3, 4 See Addendum to Care Paths



ICD-9 CODES

- 728.0
- 728.85
- 739.0
- 739.1
- 847.0
- 847.9
- 922.3
- 922.31
- 953.0

4 See Addendum to Care Paths

CARE PATH 1

CARE PATH 2

CERVICAL SPINE (NECK INJURY) HERNIATED DISC/RADICULOPATHY

HERNIATED DISC with or without
RADICULOPATHY

SOFT TISSUE INJURY
(STRAIN/SPRAIN/CONTUSION)
with
RADICULOPATHY

HERNIATED DISC with
RADICULOPATHY and SEVE
NEUROLOGICAL COMPRESS
or COMPROMISE

Conservative Therapy
(up to 2-4 weeks)

Includes:

- Provider office visits (up to 5)
- Medications¹
- Bed rest (maximum 1-2 days)
- Increasing exercise
- Consider PT program (2-3 times per week for 2-4 weeks)²

Referral to Neurology,
Physiatry, Neurosurgery, or
Orthopedic Surgery

Diagnostic Evaluation
(if not conducted previous)

- MRI
- CT
- Myelogram
- Discogram

Progressive
Neurologic
Deficit?

Test Result
(-)
◆ Go To
Conservativ
e Therapy

Test Result
(+)

YES

NO

DISC SURGERY

Post-Surgical PT
2-3 times a week for
4-6 weeks

2-4 WEEKS POST INJURY

Improvement
in symptoms
based on
objective
findings?

Improved
within 6
weeks?

YES

Continue
Conservative
Therapy

NO

Diagnostic Evaluation

May include:

- EMG (if the diagnosis of radiculopathy is obvious & specific on clinical examination, EMG testing is not recommended)
- SEP
- MRI or CT

NO

Continue PT

YES

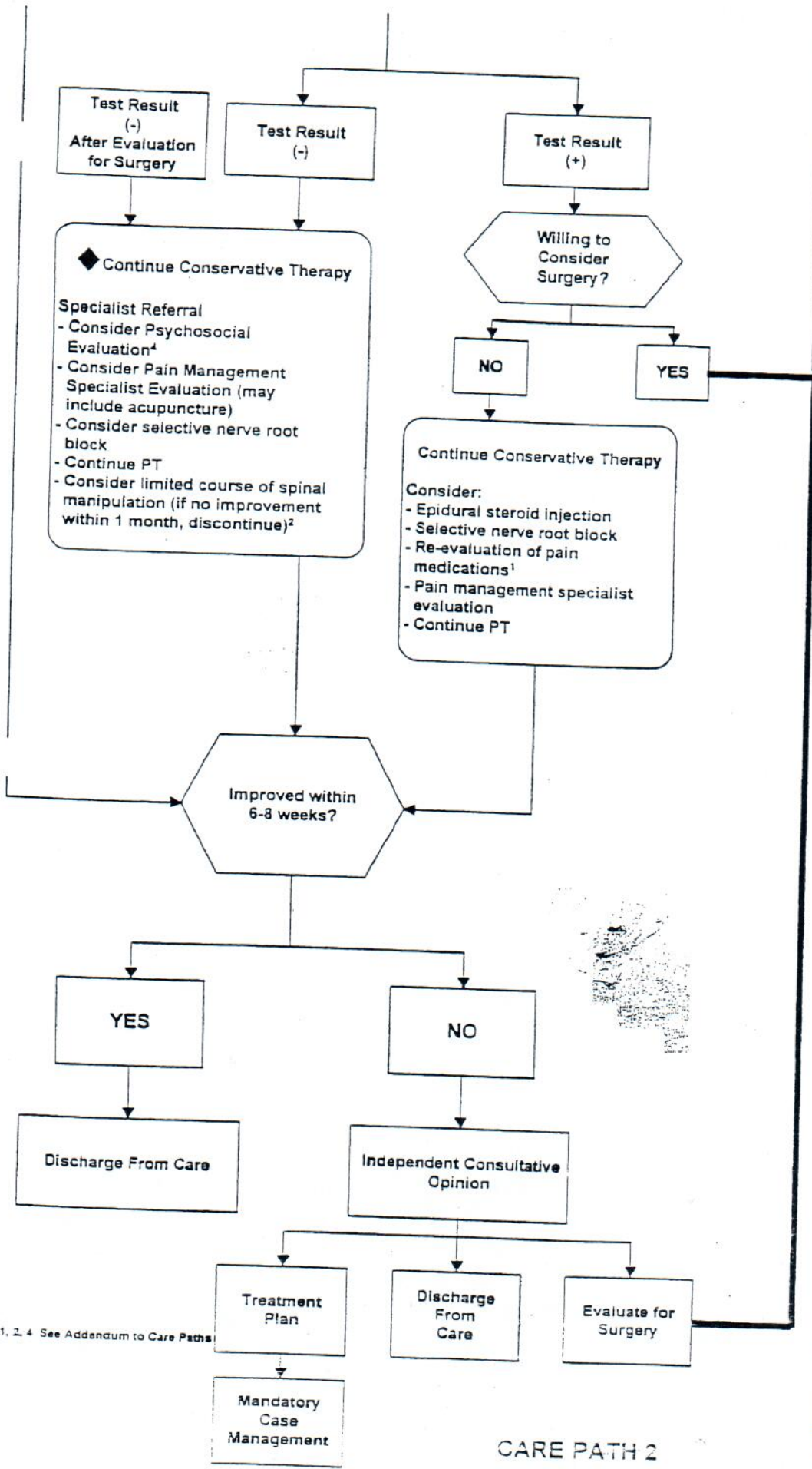
Disch
from

Improved
within 12
weeks?

NO

YES

1, 2 See Addendum to Care Paths



1, 2, 4 See Addendum to Care Paths

CARE PATH 2

ICD-9 CODES

- 722.0
- 722.2
- 722.70
- 722.71
- 728.0
- 739.0
- 953.0

NOTE: These Care Paths identify typical course of intervention. There may be patients who require more or less treatment. However, cases that deviate from the Care Paths may be subject to more careful scrutiny and may require documentation of the specific circumstances. Treatments must be based on patient need and professional judgment. Deviations may be justified by individual circumstances, such as pre-existing conditions and/or comorbidities. The Care Paths are only intended for use when the injury is caused by a motor vehicle accident (MVA). If a patient in the decision making process the health provider finds evidence that the injury was not caused by a MVA, the provider must contact the patient's insurer and medical insurance carrier.

CARE PATH 3

NOTE: These Care Paths identify typical courses of intervention. There may be patients who require more or less treatment. However, cases that deviate from Care Paths may be subject to more careful scrutiny and may require documentation of the special circumstances. Treatments must be based on patient need and professional judgment. Deviations may be justified by individual circumstances, such as pre-existing conditions and/or comorbidities. The Care Paths are only intended for use when the injury was caused by a motor vehicle accident (MVA). If at any point in the decision making process the healthcare provider finds that the injury was not caused by a MVA, the provider must contact the patient's PIP carrier and medical insurance carrier.

THORACIC SPINE SOFT TISSUE INJURY (STRAIN/SPRAIN/CONTUSION) OF THE UPPER BACK

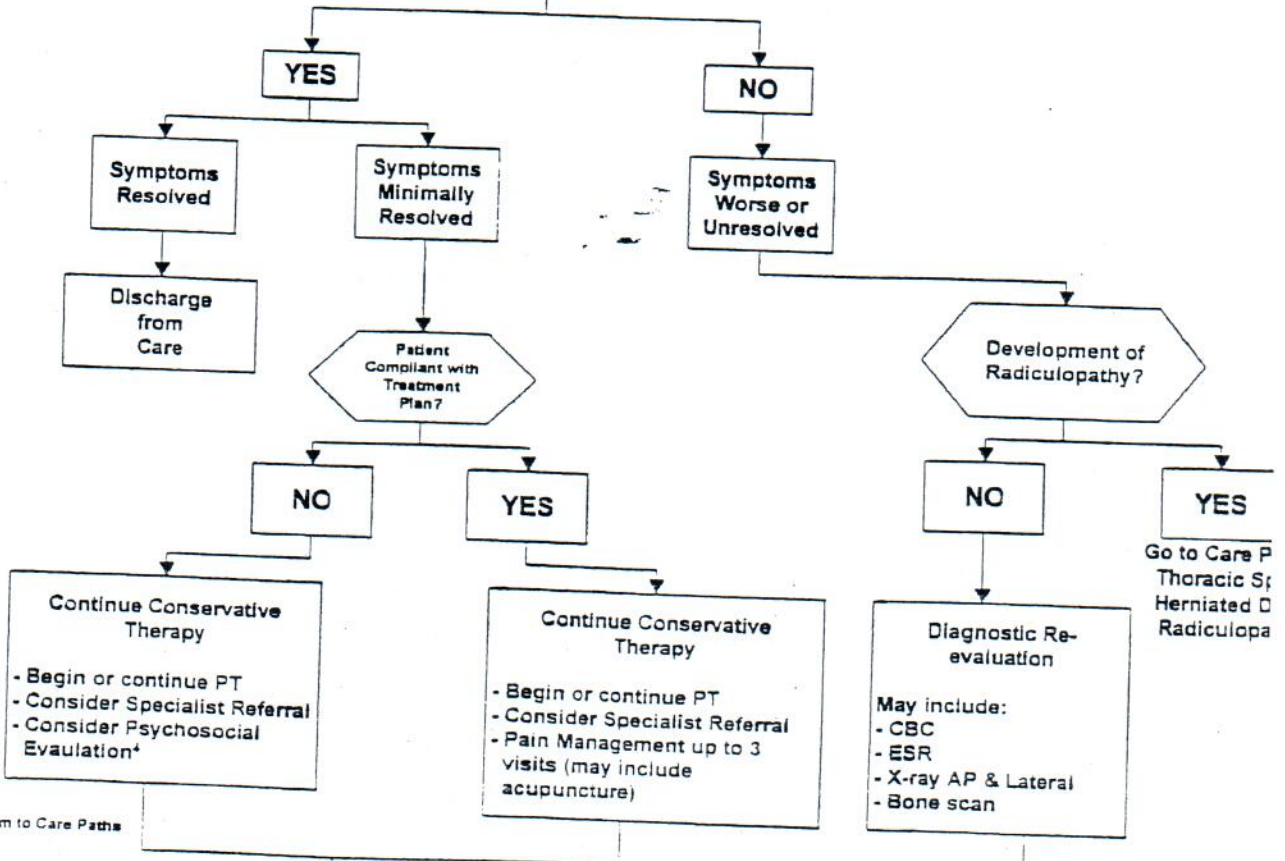
CONSERVATIVE THERAPY
(up to 4 weeks)

- Provider office visits (up to 5)
- Medication¹
- Bed rest (maximum 2-4 days)
- Increasing exercise
- Consider PT program (2-3 times a week for 2-4 weeks)²
- Spinal manipulation² (1-3 visits per week, up to 4 weeks)

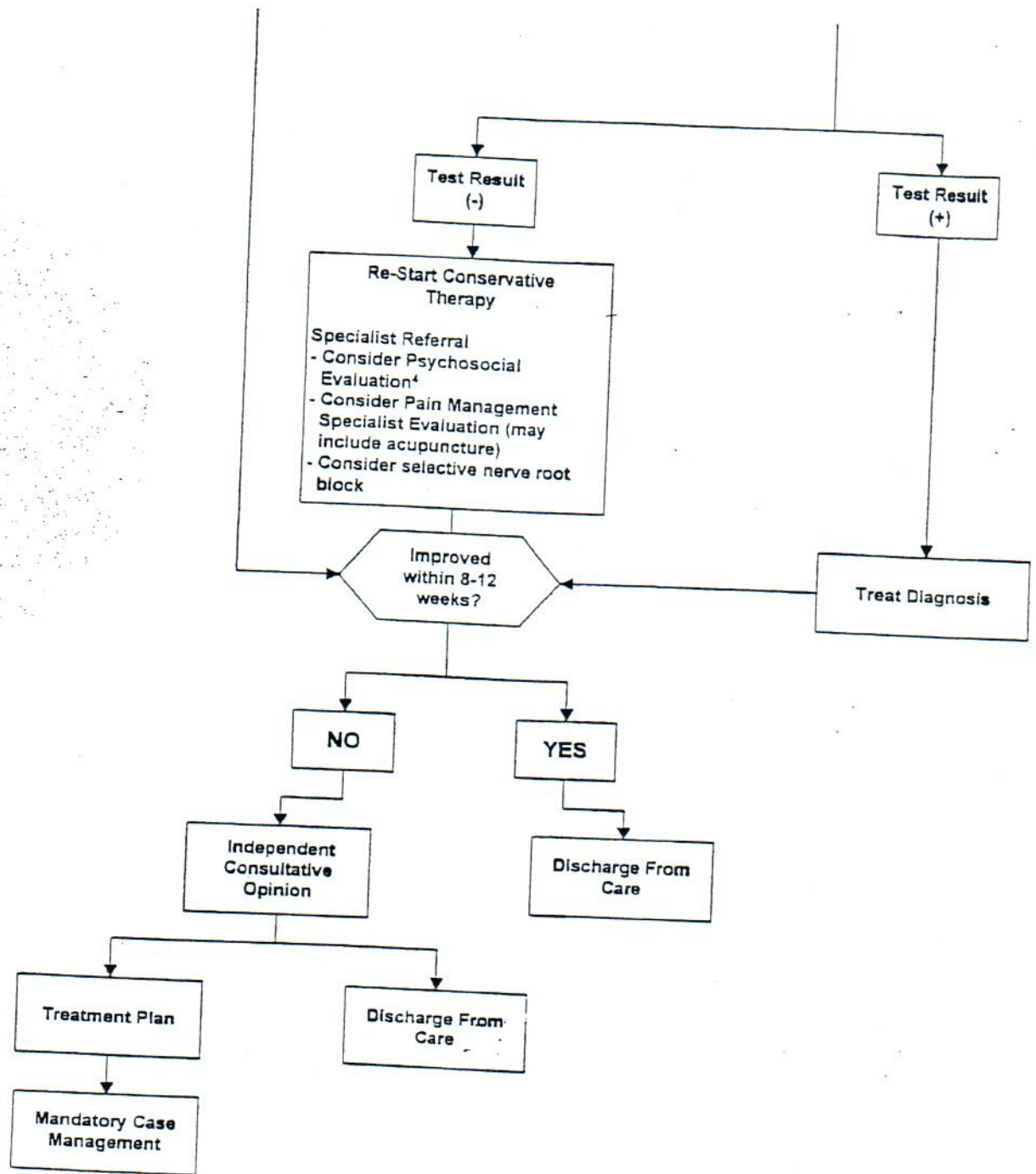
(The total number of visits for physical therapy and spinal manipulation should not exceed 12.)

4 WEEKS POST INJURY

Improvement in symptoms based on objective findings?



1, 2, 3, 4 See Addendum to Care Paths



ICD-9 CODES

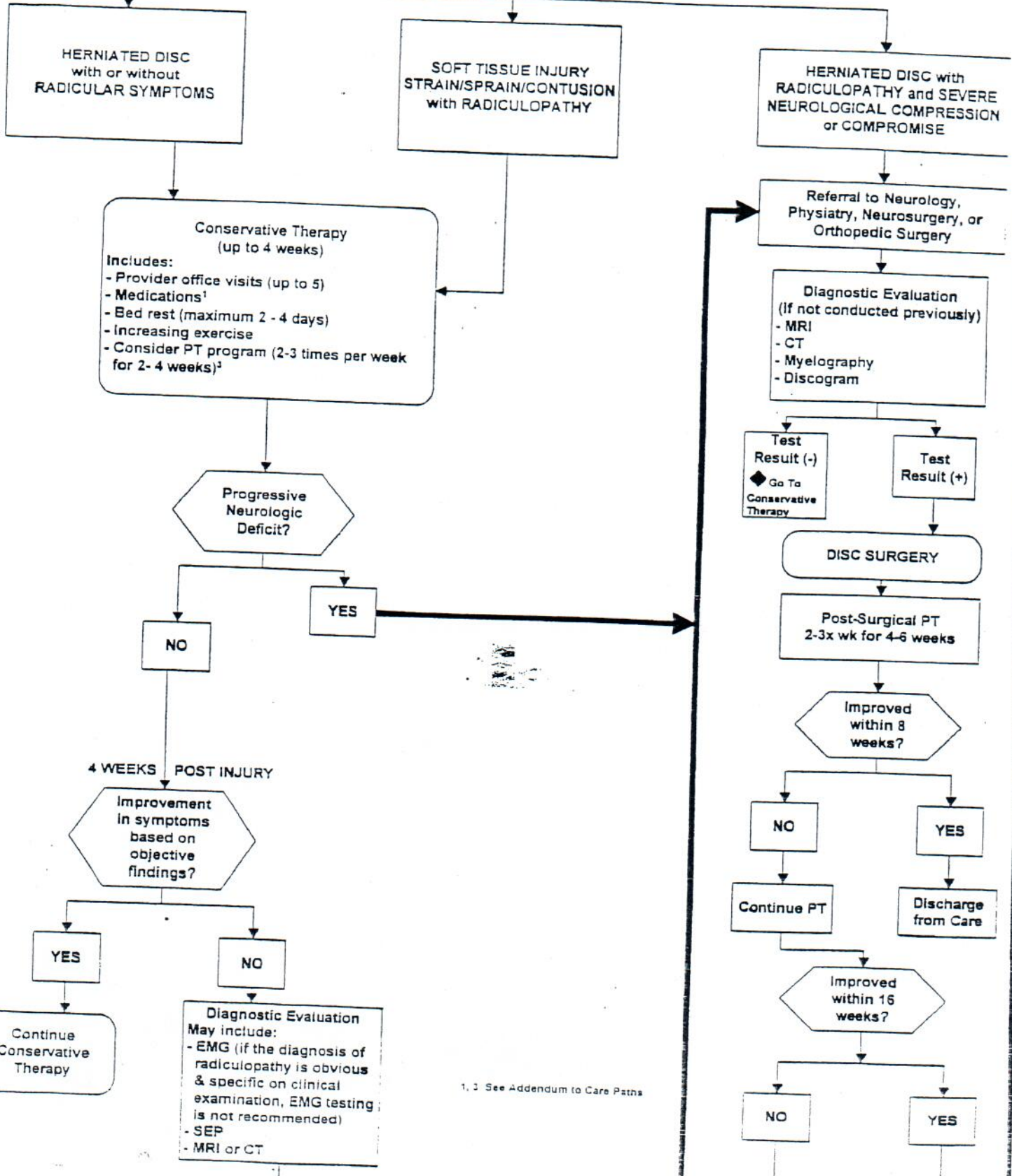
- 728.0
- 728.85
- 739.0
- 739.7
- 739.8
- 847.1
- 847.9
- 922.3
- 922.33
- 953.2

* See Addendum to Care Paths

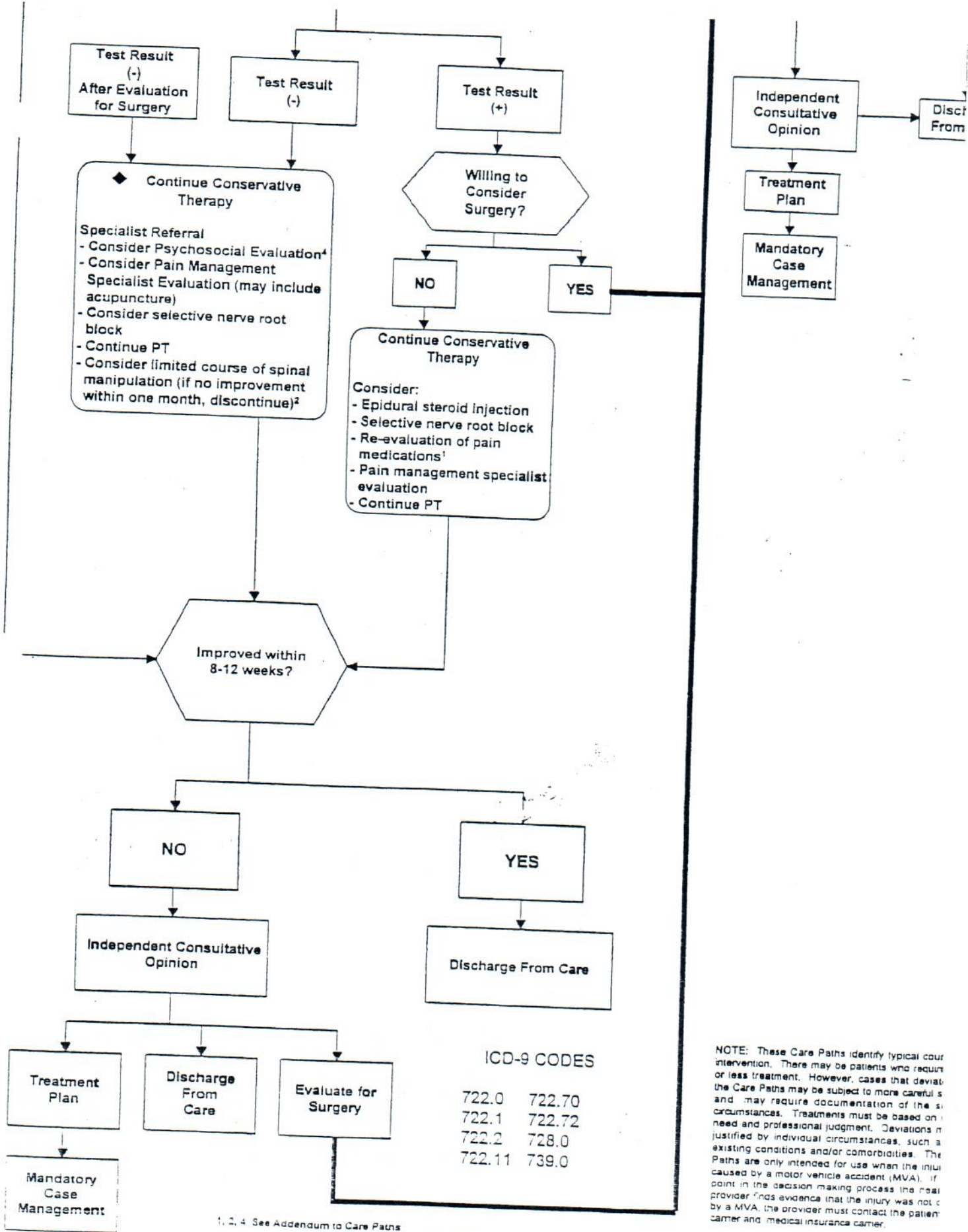
CARE PATH 3

CARE PATH 4

THORACIC SPINE (UPPER BACK INJURY) HERNIATED DISC/RADICULOPATHY



1, 3 See Addendum to Care Paths



1, 2, 4 See Addendum to Care Paths

CARE PATH 4

CARE PATH 5

LUMBAR-SACRAL SPINE SOFT TISSUE INJURY (STRAIN/SPRAIN/CONTUSION) OF THE LOW BACK

NOTE: These Care Paths identify typical courses of intervention. There may be patients who require more or less treatment. However, cases that deviate from the Care Paths may be subject to more careful scrutiny and may require documentation of the special circumstances. Treatments must be based on patient need and professional judgment. Deviations may be justified by individual circumstances, such as pre-existing conditions and/or comorbidities. The Care Paths are only intended for use when the injury was caused by a motor vehicle accident (MVA). If at any point in the decision making process the healthcare provider finds evidence that the injury was not caused by a MVA, the provider must contact the patient's PIP carrier and medical insurance carrier.

CONSERVATIVE THERAPY (up to 4 weeks)

- Provider office visits (up to 5)
- Medications¹
- Bed rest (maximum 2-4 days)
- Increasing exercise
- Consider PT program (2-3 times per week for 2-4 weeks)²
- Spinal manipulation² (1-3 visits per week, up to 4 weeks)

(The total number of visits for physical therapy and spinal manipulation should not exceed 12.)

4 WEEKS POST INJURY

Improvement in symptoms based on objective findings?

YES

Symptoms Resolved

Discharge from Care

Symptoms Minimally Resolved

Patient Compliant with Treatment Plan?

NO

Continue Conservative Therapy

- Begin or continue PT
- Consider Specialist Referral
- Consider Psychosocial Evaluation³

YES

Continue Conservative Therapy

- Begin or continue PT
- Consider Specialist Referral
- Pain Management up to 3 visits (may include acupuncture)

NO

Symptoms Worse or Unresolved

Development of Radiculopathy?

NO

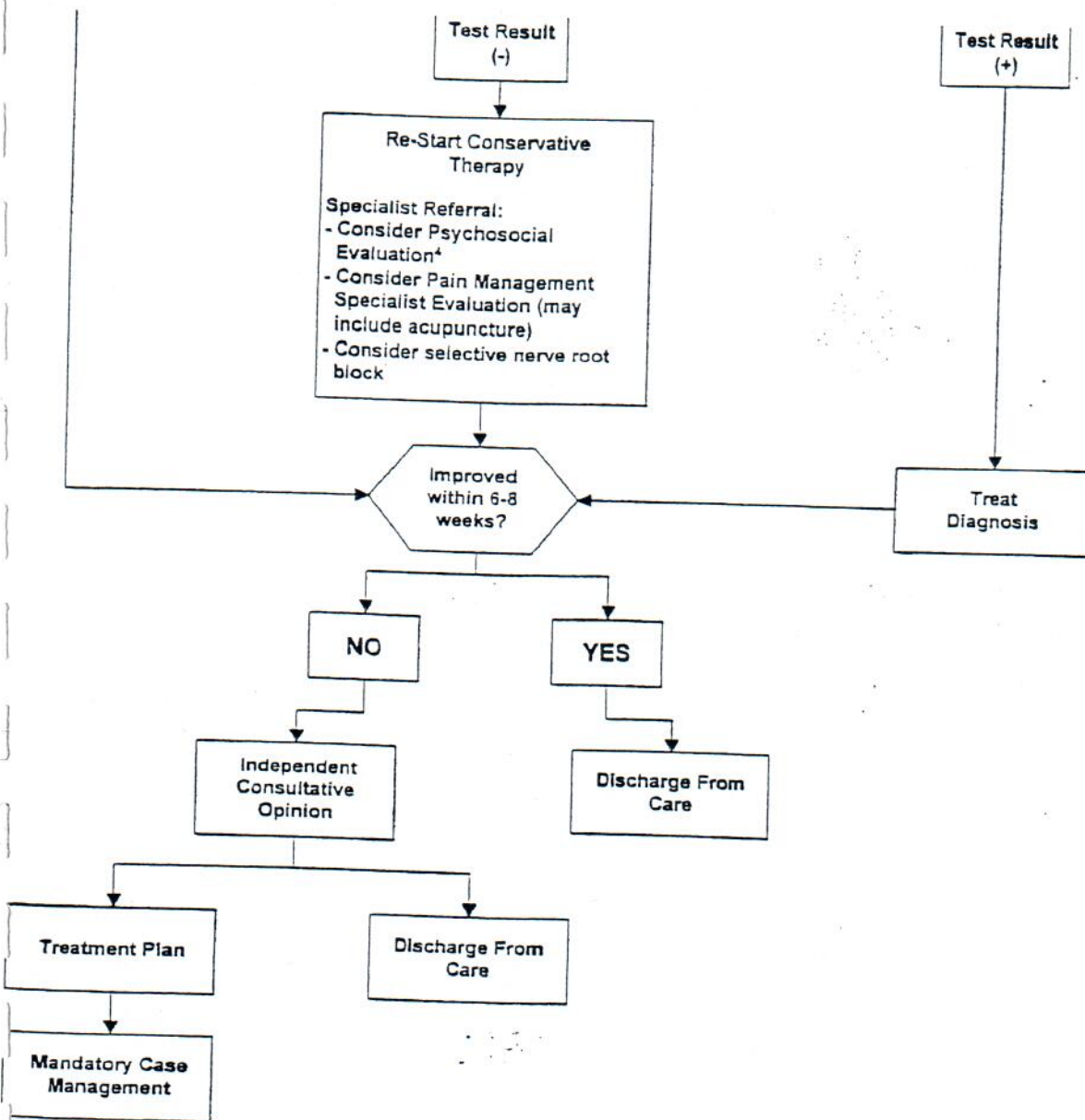
Diagnostic Re-evaluation

- May Include:
- CBC
 - ESR
 - X-ray AP & Lateral
 - Bone scan

YES

Go to Care Path 6 Lumbar-Sacral Spine Herniated Disc/Radiculopathy

1, 2, 3, 4 See Addendum to Care Paths



ICD-9 CODES

- 728.0 846.8
- 728.85 846.9
- 739.0 847.2
- 739.3 847.3
- 739.4 847.4
- 846 847.9
- 846.0 922.3
- 846.1 922.31
- 846.2 953.2
- 846.3 953.3

CARE PATH 5

⁴ See Addendum to Care Paths

CARE PATH 6

LUMBAR-SACRAL SPINE
(LOW BACK INJURY)
HERNIATED DISC/RADICULOPATHY

HERNIATED DISC
with or without
RADICULAR SYMPTOMS

SOFT TISSUE INJURY
STRAIN/SPRAIN/CONTUSION
with
RADICULOPATHY

HERNIATED DISC with
RADICULOPATHY and SEVERE
NEUROLOGICAL COMPRESSIO
or COMPROMISE

Conservative Therapy
(up to 4 weeks)
Includes:
- Provider office visits (up to 5)
- Medications¹
- Bed rest (maximum 2 - 4 days)
- Increasing exercise
- Consider PT program (2-3 times per week
for 2-4 weeks)²

Referral to Neurology,
Physiatry, Neurosurgery, or
Orthopedic Surgery

Diagnostic Evaluation
(if not conducted previously)
- MRI
- CT
- Myelogram
- Discogram

Progressive
Neurologic
Deficit?

Test Result
(-) Go To
Conservative
Therapy

Test Res
(+)

NO

YES

DISC SURGERY

Post-Surgical PT
2-3 times a week for
4-8 weeks

4 WEEKS POST INJURY

Improvement
in symptoms
based on
objective
findings?

Improved
within 8
weeks?

YES

NO

NO

YES

Continue
Conservative
Therapy

Diagnostic Evaluation
May include:
- EMG (if the diagnosis of
radiculopathy is obvious
& specific on clinical
examination, EMG testing
is not recommended)
- SEP
- MRI or CT

Continue PT

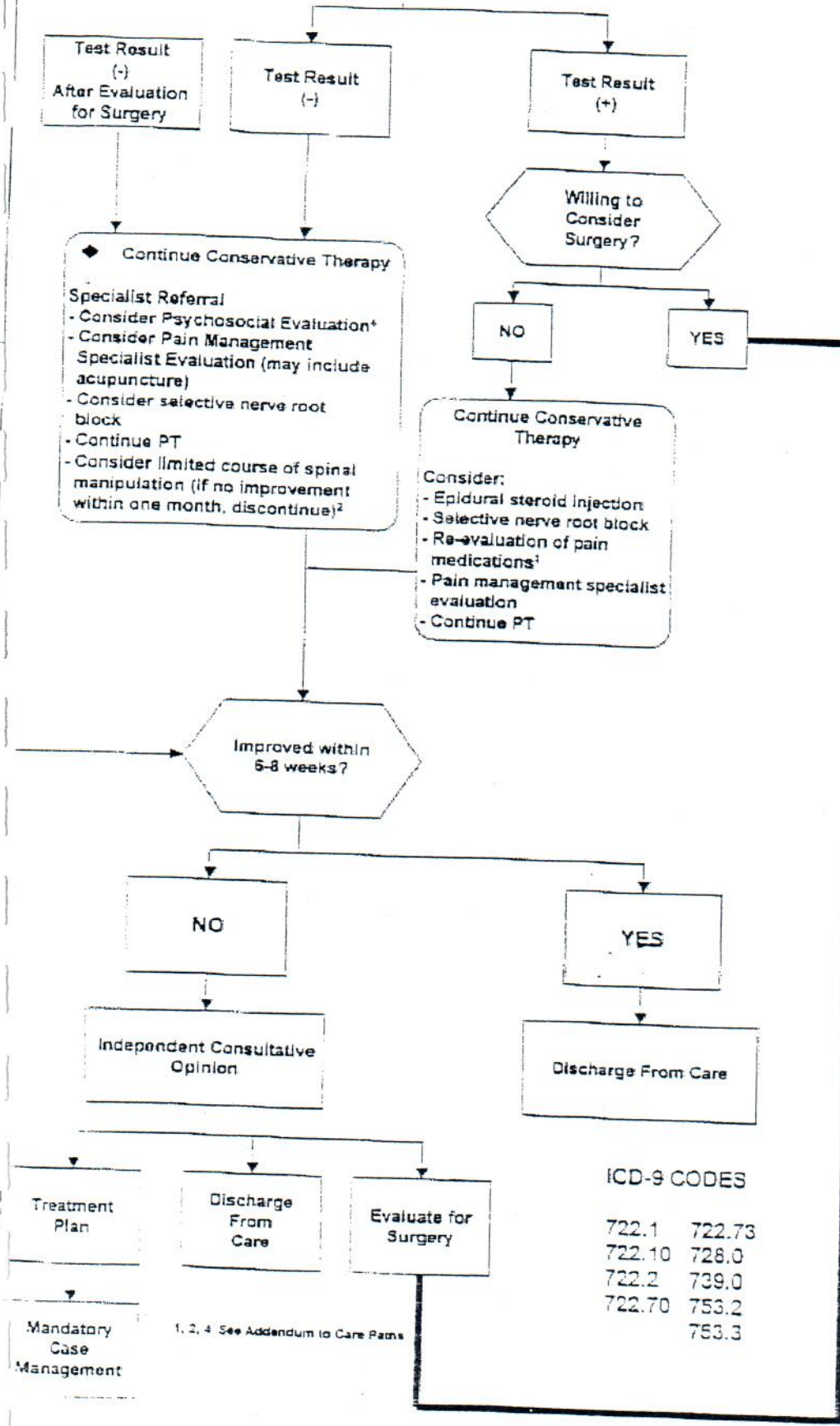
Discharge
from Care

Improved
within 16
weeks?

NO

YES

1, 2 See Addendum to Care Paths



ICD-9 CODES

722.1	722.73
722.10	728.0
722.2	739.0
722.70	753.2
	753.3

1, 2, 4 See Addendum to Care Paths

NOTE: These Care Paths identify typical courses of intervention. There may be patients who require more or less treatment. However, cases that deviate from the Care Paths may be subject to more careful scrutiny and may require documentation of the special circumstances. Treatments must be based on patient need and professional judgment. Deviations may be justified by individual circumstances, such as pre-existing conditions and/or comorbidities. The Care Paths are only intended for use when the injury was caused by a motor vehicle accident (MVA). If at any point in the decision making process the healthcare provider finds evidence that the injury was not caused by a MVA, the provider must contact the patient's PIP carrier and medical insurance carrier.

CARE PATH 6

TREATMENT OF ACCIDENTAL INJURY TO THE SPINE AND BACK
CARE PATH - DIAGNOSIS CO

EXHIBIT 9

The following **International Classification of Diseases, 9th** Revision Clinical Modification - fifth edition **ICD-9-CM** diagnostic codes are associated with Care Path 1 through Care Path 6 for treatment of Accidental Injury to the Spine and Back and are included on each appropriate Care Path. The ICD9 codes referenced do not include codes for multiple diagnoses or co-morbidity.

Care Path 1

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

Care Path 2

722.0 Displacement of cervical intervertebral disc without myelopathy
2722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
722.70 Intervertebral disc disorder with myelopathy, unspecified region
722.71 Intervertebral disc disorder with myelopathy, cervical region
728.0 Disorders of muscle, ligament and fascia
739.0 Non allopathic lesions - not elsewhere classified
953.0 Injury to cervical root

Care Path 3

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

Care Path 4

722.0 Displacement of cervical intervertebral disc without myelopathy
722.1 Displacement of thoracic or lumbar intervertebral disc without myelopathy
722.11 Displacement of thoracic intervertebral disc without myelopathy
722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
722.70 Intervertebral disc disorder with myelopathy, unspecified region

722.72 Intervertebral disc disorder with myelopathy, thoracic region
728.0 Disorders of muscle, ligament and fascia
739.0 Non allopathic lesions - not elsewhere classified

Care Path 5

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

Care Path 6

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

The following **ICD-9-CM** supplemental classification of external causes of injury may be used in addition to the specific diagnostic codes noted above and on each Care Path:

- E 810 through E 819, selected E 820 series codes.

These codes may be used to indicate cause of injury as motor vehicle accident but should not be used without an associated diagnostic code.

ADDENDUM TO CARE PATHS
EXHIBIT 10

1. Medications

Muscle Relaxants

- Muscle relaxants are an option in the treatment of patients with acute neck, thoracic, and low back problems. While probably more effective than placebo, muscle relaxants have not been shown to be more effective than NSAIDs.
- No additional benefit is gained by using muscle relaxants in combination with NSAIDs over using NSAIDs alone.
- Muscle relaxants have potential side effects in 30 percent of patients. When considering the option of using relaxants, the clinician should balance the potential patient's intolerance of other agents.

Opioid Analgesics

- When used for a time-limited course, opioid analgesics are an option in the management of patients with acute neck, thoracic, and low back problems. The decision to use opioids should be guided by consideration of their potential complications relative to other options.
- Opioids appear to be more effective in relieving neck, thoracic, and low back symptoms than safer analgesics, such as acetaminophen or aspirin or other NSAIDs.
- Clinicians should be aware of the side effects of opioids, such as decreased reaction time, clouded judgment, and drowsiness, which lead to early discontinuation by as many as 35 percent of patients.
- Patients should be warned about dependence and the danger of opioids while operating heavy machinery.

Oral Steroids

- Oral steroids are not recommended for the treatment of acute neck, thoracic, or low back problems.
- A potential for severe side effects is associated with the extended use of oral steroids or steroids in high doses.

2. Who May Perform Spinal Manipulation:

- Spinal manipulation may be performed by those providers licensed or certified to perform this procedure within their scope of practice.

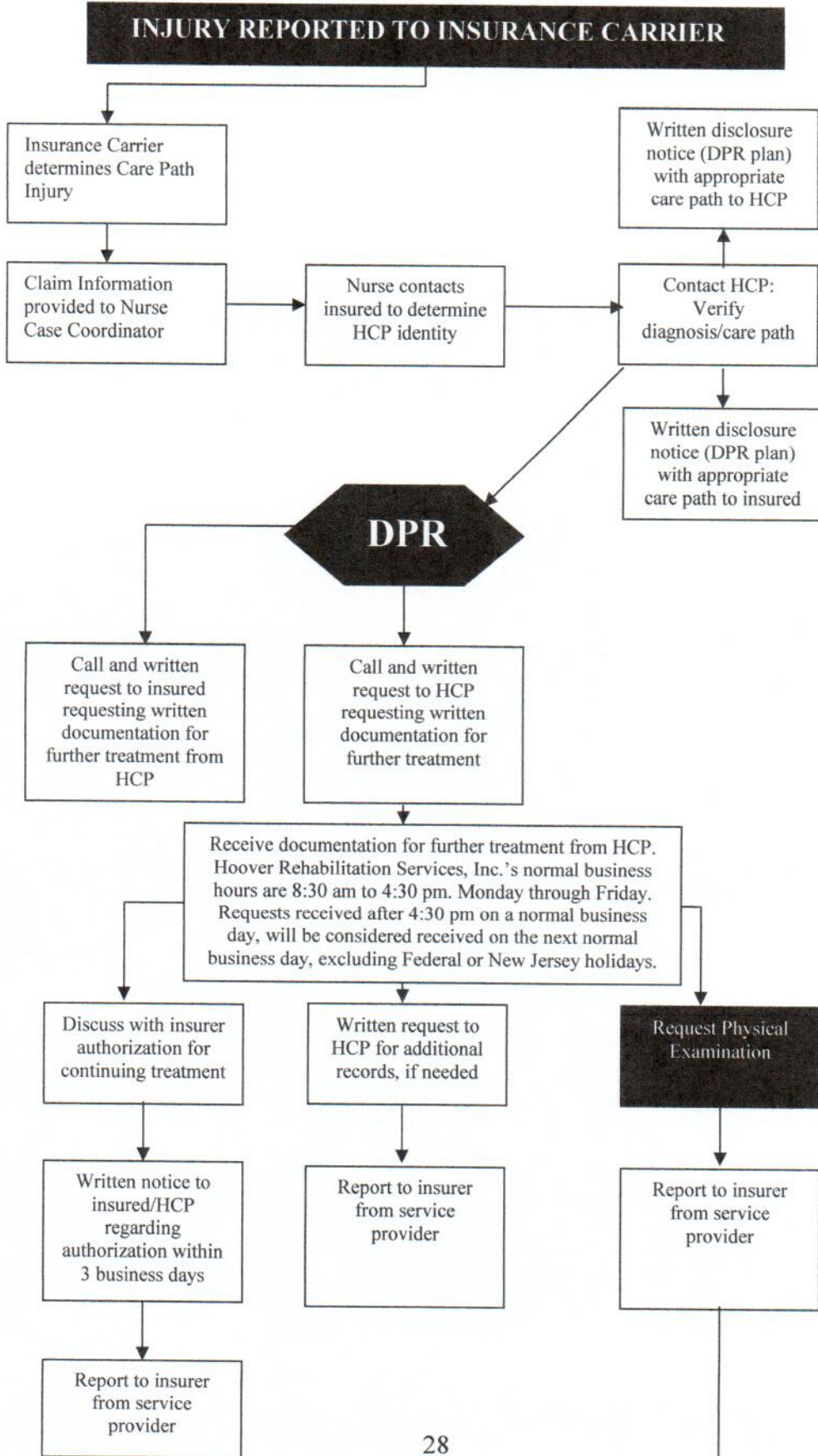
3. Spinal Manipulation/Chiropractic Care

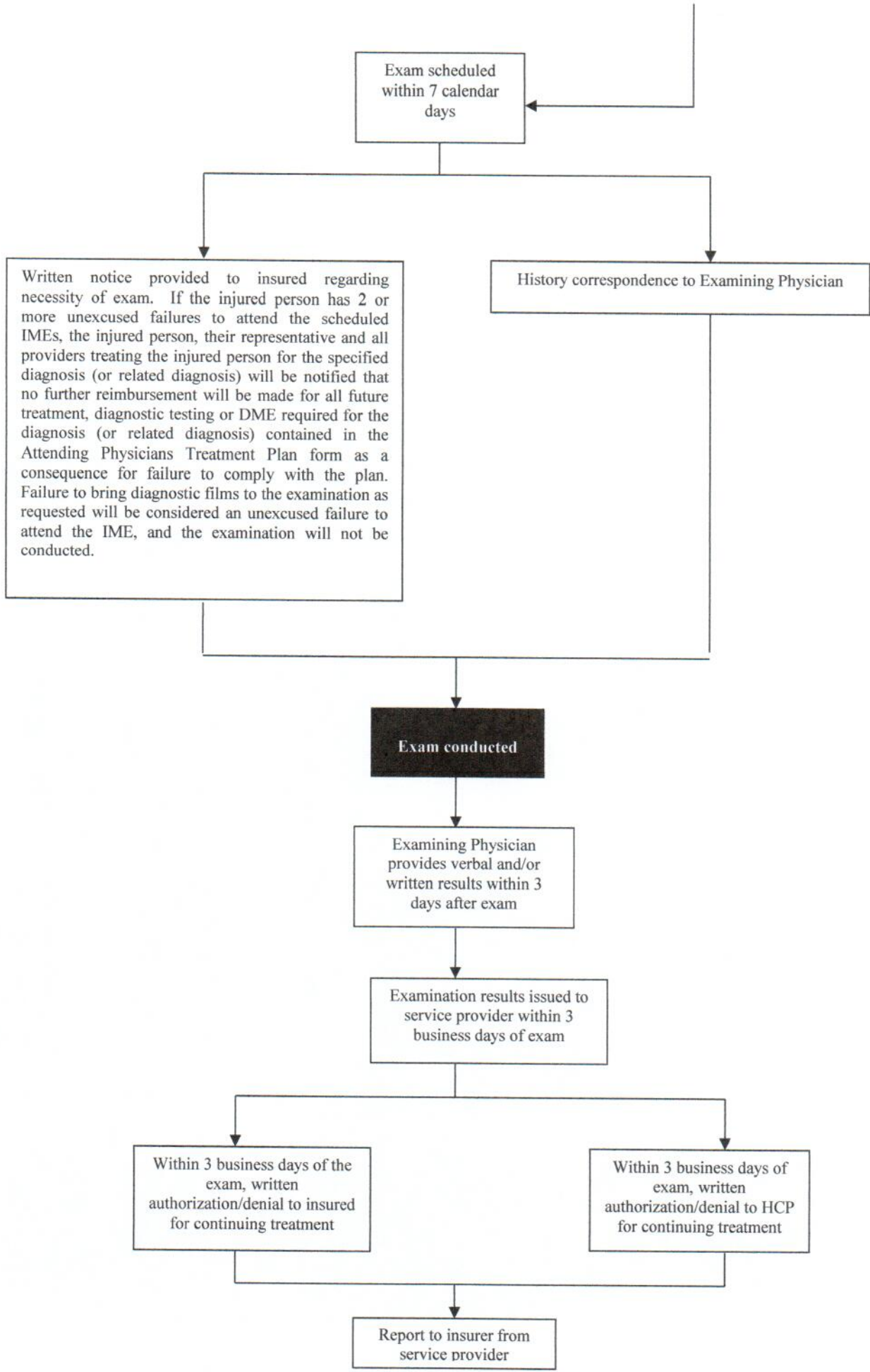
- A course of spinal manipulation/chiropractic care may be considered as conservative therapy on all Care Paths. If there is no improvement within one month, then immediate reevaluation is indicated to determine appropriate further treatment and treatment options, including referral to other health care providers and/or modification of conservative therapy.
- When findings suggest progressive or severe neurologic deficits, an appropriate diagnostic assessment to rule out serious neurologic conditions is indicated in any conservative therapy.

4. Mental Health/Rehabilitation Assessment Option If Patient Has Not Responded To Treatment

- A mental health/rehabilitation assessment can be obtained if psychological/ psychosocial or psychiatric distress is obvious from the history, i.e., presence of "non-organic" physical signs, repetitive back injuries, failed previous treatments, litigation or disability compensation claims, family or financial problems, apparent secondary gain, boredom and dissatisfaction with job, frequent bouts of pain, depression, alcohol and substance abuse, extreme obesity, and apparent psychiatric behavior.

HOOVER REHABILITATION SERVICES, INC. DECISION POINT REVIEW SYSTEM





HOOVER REHABILITATION SERVICES, INC. RECONSIDERATION/APEAL PROCESS

If Hoover is unable to certify or renders a determination not to certify an admission, hospital stay, treatment plan, diagnostic test, or other service, the attending or ordering provider will have the opportunity to request reconsideration by the Physician Advisor who made the initial determination.

Hoover Rehabilitation Services, Inc.'s normal business hours are 8:30 am to 4:30 pm. Monday through Friday. Requests received after 4:30 pm on a normal business day, will be considered received on the next normal business day, excluding Federal or New Jersey holidays.

Attending/Ordering Provider initiates reconsideration process by telephoning Hoover at 1-877-704-4440

Reconsideration request submitted to Hoover using either Pre-Service Appeal form or Post-Service Appeal form, along with supporting documentation. Hoover will respond to Pre-Service Appeals within 3 business day and Hoover, the Repricing Dept. or Insurance Claims Adjuster will respond to Post-Service Appeals within 30 calendar days.

Initial Determination reversed per reconsideration review and approval granted to treatment plan.

Initial Determination upheld per reconsideration review, and Attending/Ordering Provider informed of right to appeal to state-mandated MRO through National Arbitration Forum at 732-231-6100.

Key:

DPR: Decision Point Review

Examining Physician: Independent Physician conducting exam for authorization/denial of treatment/tests

HCP: Treating Healthcare Provider

Insured: Policyholder

Insurer: Insurance Carrier

Service Provider: Hoover Rehabilitation Services, Inc.

Hoover Rehabilitation Services, Inc.
C/O (Insurance Co.)
(Address)
(Address)

Date:

Via Certified and 1st Class Mail

RE: Patient Name:
Claim Number:
Date of Injury:

Dear Dr. _____ :

The patient noted above was involved in a motor vehicle accident (MVA) on _____. We have been informed that he/she will receive treatment with you. Pursuant to N.J.A.C. 11:3-4, et seq, as amended, you are required to provide us with notification for certain tests you may order, or services you may perform on the patient. As described more fully below, this notification is provided in connection with Decision Point Review and Precertification. Hoover Rehabilitation Services, Inc. has been requested by _____, to be the Utilization Review Organization involved with the Decision Point Review/Precertification process. Decision Point Review/Precertification does not apply until the **10th day** following the MVA and does not apply to Emergency Care. Hoover Rehabilitation Services, Inc.'s normal business hours are 8:30 am to 4:30 pm. Monday through Friday.

DECISION POINT REVIEW

Pursuant to N.J.A.C. 11:3-4, et seq., as amended, the New Jersey Department of Banking and Insurance (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**. (For a list of Identified Injuries by ICD-10 codes, see Exhibit A.) N.J.A.C. 11:3-4, et seq., as amended also establishes guidelines for the use of certain diagnostic tests. The **Care Paths** provide that treatment be evaluated at certain intervals called **Decision Points**. On the Care Paths, Decision Points are represented by hexagonal boxes. At Decision Points, you must provide us information about further treatment you intend to provide (**Decision Point Review**). In addition, the administration of any test on the list in Exhibit B also requires **Decision Point Review** regardless of the diagnosis. The **Care Paths** and accompanying rules are available on the Internet on the Department's website at <http://www.nj.gov/dobi/aicrapg.htm> (scroll down to NJAC 11:3-4, Medical Protocols Rule [Care Paths, Decision Point Review, Precertification]) or by calling Hoover Rehabilitation Services, Inc. at 1-877-704-4440. If you fail to submit requests for

Decision Point Reviews, or fail to provide clinically supported findings that support the request, payment of your bills will be subject to a penalty co-pay of 50%, even if the services are determined to be medically necessary.

MANDATORY PRECERTIFICATION

If your patient does not have an Identified Injury, you are required to obtain Precertification of all services itemized in Exhibit B. If you fail to precertify such services or fail to submit clinically supported findings to support the request, payment of your bills will be subject to a penalty co-pay of 50%, even if the services are determined to be medically necessary. You are encouraged to maintain communication with Hoover Rehabilitation Services, Inc. on a regular basis as precertification requirements may change. For your convenience, the Hoover Rehabilitation Services, Inc. website, www.hooverinc.com contains Precertification requirements, or, we can be reached at 1-877-704-4440.

VOLUNTARY PRECERTIFICATION

You are encouraged to participate in a **Voluntary Precertification** process by providing Hoover Rehabilitation Services, Inc. with a comprehensive treatment plan for both identified and other injuries. Hoover Rehabilitation Services, Inc. will utilize nationally-accepted criteria and the Care Paths to work with you to certify a mutually agreeable course of treatment to include itemized services and a defined treatment period. In consideration for your participation in the **Voluntary Precertification** process, the bills you submit, when consistent with the precertified services, will be paid without utilization audit. In addition, having an approved treatment plan means that as long as treatment is consistent with the plan, additional notification to Hoover Rehabilitation Services, Inc. at Decision Points is not required. As you continue to participate in the **Voluntary Precertification** process for subsequent services, payment for precertified services will be made without utilization audit.

HOW TO SUBMIT DECISION POINT/PRE CERTIFICATION REQUESTS

In order to complete our review, we require that you provide us with any past medical history that is available. We also require the diagnosis, all x-ray and other test results that may have been completed, and documentation of all treatment provided to date. Please indicate any tests or treatment you anticipate over the next 30 days.

Enclosed is an "ATTENDING PROVIDER TREATMENT PLAN" form that you must use. Please return this completed form, along with a copy of the most recent/appropriate progress notes, and results of diagnostic tests or studies relative to the requested services or FAX (570-283-1637). If you have any questions regarding your request, you may telephone us at 1-877-704-4440.

Our review of Decision Point/Precertification requests and voluntary precertification requests will be completed within three business days of receipt of the necessary information. Requests received after 4:30 pm on a normal business day, will be considered received on the next normal business day, excluding Federal or New Jersey holidays. Notice of certification will be made to your office by telephone and confirmed in writing. If we fail to notify you within three business days, you may continue with the test or treatment until a final determination is communicated to

you. In addition, if an independent physical or mental examination is required, treatment may proceed while the exam is being scheduled and the results become available.

REVIEW OUTCOMES

- Requested service is certified.
- In the event we receive insufficient information that does not support the requested service, an administrative denial will be issued and will continue until we receive documentation sufficient to evaluate the request for the diagnostic test or treatment service. Once we receive sufficient documentation a decision will be communicated to you within 3 business days of receipt of the documentation.
- Any denial of reimbursement for further treatment or testing will be made by a physician or dentist.
- In the event that we must amend the requested services (either frequency, duration, intensity or place of service or treatment), your office will be notified by telephone and confirmed in writing and a Hoover Rehabilitation Services, Inc. physician advisor will be available to discuss the case with you.
- In the event we are unable to certify the request, your office will be notified by telephone and confirmed in writing. A Hoover Rehabilitation Services, Inc. physician advisor will be available to discuss the case with you. If the request is for a surgical procedure, we will assist the patient/insured to schedule a second surgical opinion, at the expense of Insurance Company.
- Pursuant to N.J.A.C. 11:3-4, et seq., as amended and the patient's/Insured's policy: Failure to request 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 additional co-payment not to exceed 50% of the eligible charge for medically necessary diagnostic tests, treatments or durable medical goods that were provided between the time of notification to the insurer was required and the time that proper notification is made and the insurer has an opportunity to respond in accordance with its approved decision point review plan.

RECONSIDERATION PROCESS

If your request does not meet certification criteria, clinical rationale for this determination is available upon request. You are encouraged to utilize Hoover's internal review process for reconsideration by contacting Hoover Rehabilitation Services, Inc. at 1-877-704-4440. We have attached both the Pre-Service Appeal Form and the Post-Service Appeal form for your convenience. The Pre-Service and Post-Service Appeal forms, along with supporting documentation should be submitted via fax to 570-283-1637. Enclosed as "Exhibit C", is detailed information regarding the Reconsideration and Appeal Process.

VOLUNTARY NETWORK SERVICES

Please note that your patient's policy includes a voluntary Utilization Program for Prescription Drugs, Durable Medical Equipment over \$50 or rental for more than 30 days, Diagnostic Imaging including Magnetic Resonance Imaging (MRI), Computer Assisted Tomography (CAT)

and electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b)1 through 3 except for needle EMGs, H-reflex and nerve conduction velocity (NCV) tests performed together by the treating physician. If an insured utilizes a conveniently located network provider for these services/tests, 30% co-pay (\$10 for prescription drugs) will be waived. Hoover Rehabilitation Services, Inc. is contracted with ALTA SERVICES, LLC, dba CHN Solutions for voluntary network services. Information regarding the availability of network providers can be found at <http://www.chnnetwork.com/volnets/> or by calling Hoover Rehabilitation Services, Inc. at 1-877-704-4440.

INDEPENDENT MEDICAL EVALUATIONS

In the event that your patient is requested to attend an Independent Medical Evaluation (IME), you, your patient and legal representative (if applicable) will be notified of the appointment via correspondence. Repeated unexcused failure to attend the scheduled IMEs may result in a termination of your patient's benefits. If the patient is unable to attend the IME for any reason, they must provide at least 48 hours notice to the Nurse Case Coordinator at 1-877-704-4440. If the injured person has 2 or more unexcused failures to attend the scheduled IMEs, the injured person, their representative and all providers treating the injured person for the specified diagnosis (or related diagnosis) will be notified that no further reimbursement will be made for all future treatment, diagnostic testing or DME required for the diagnosis (or related diagnosis) contained in the Attending Physicians Treatment Plan form as a consequence for failure to comply with the plan. Failure to hand carry diagnostic films to the examination as requested will be considered an unexcused failure to attend the IME, and the examination will not be conducted.

The independent medical examination will be conducted within 7 calendar days of receipt of the request unless the claimant agrees to extend the time frame. The exam will be conducted in a location convenient to the claimant and conducted by a provider in the same discipline as the treating provider. The claimant will provide the medical records or diagnostic films to the provider conducting the examination at or before the examination.

The claimant and their treating provider will be notified of the decision whether to reimburse for further treatment, diagnostic tests, or DME within 3 business days after the examination. If the examining provider prepares a written report concerning the examination, the claimant or their designee is entitled to a copy of the report upon request.

ASSIGNMENT OF BENEFITS

Benefits are not assignable except to providers of service. Any such assignment is not enforceable unless you agree 1) to be subject to the requirements of our Decision Point Review/Precertification Plan, 2) to hold the insured harmless against penalty co-payments based on your failure to follow our Decision Point Review/Precertification Plan and 3) to submit any dispute to alternate dispute resolution pursuant to N.J.A.C. 11:3-5.

The staff at Hoover Rehabilitation Services, Inc. remains available to you and your patient, to answer questions and assist with the precertification process.

Thank you for your continued cooperation

Sincerely,

HOOVER REHABILITATION SERVICES, INC.
Precertification Department

Nurse Case Coordinator

Enclosures: Exhibits A, B, C, & D
Attending Physicians Treatment Plan Form
Pre-Service Appeal Form
Post Service Appeal form

CC:

Hoover Rehabilitation Services, Inc.
C/O (Insurance Co.)
(Address)
(Address)

Via Certified and 1st Class Mail

RE: Patient Name:
Claim Number:
Date of Injury:

Dear :

Our records reflect that you were involved in a motor vehicle accident (MVA) on . We have been informed that you are currently receiving treatment. Pursuant to N.J.A.C. 11:3-4, et seq., as amended, your physician is required to provide us with notification for certain tests he/she may order, or services provided to you. As described more fully below, this notification is provided in connection with Decision Point Review and Precertification. Hoover Rehabilitation Services, Inc. has been requested by Insurance Company, (your auto insurance carrier) to be the Utilization Review Organization involved with the Decision Point Review/Precertification process. Decision Point Review/Precertification does not apply until the **10th day** following the MVA and does not apply to Emergency Care. Hoover Rehabilitation Services, Inc.'s normal business hours are 8:30 am to 4:30 pm. Monday through Friday.

DECISION POINT REVIEW

Pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance (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**. (For a list of Identified Injuries by ICD-9 codes, see Exhibit A.) N.J.A.C. 11:3-4, et seq., as amended, also establishes guidelines for the use of certain diagnostic tests. The **Care Paths** provide that treatment be evaluated at certain intervals called **Decision Points**. On the Care Paths, Decision Points are represented by hexagonal boxes. At Decision Points, your physician must provide us information about further treatment he/she intends to provide (**Decision Point Review**). In addition, the administration of any test on the list in Exhibit B also requires **Decision Point Review** regardless of the diagnosis. The **Care Paths** and accompanying rules are available on the Internet on the Department's website at <http://www.nj.gov/dobi/aicrapg.htm> (scroll down to NJAC 11:3-4, Medical Protocols Rule [Care Paths, Decision Point Review, Precertification]) or by calling Hoover

Rehabilitation Services, Inc. at 1-877-704-4440. If your physician fails to submit requests for Decision Point Review or fails to provide clinically supported findings that support the request, payment of your bills will be subject to a penalty co-payment of 50%, even if the services are determined to be medically necessary.

MANDATORY PRECERTIFICATION

If you *did not* sustain an Identified Injury, your physician is required to obtain precertification of all services itemized in Exhibit B. If your physician fails to precertify such services, or fails to submit clinically supported findings to support the request, payment of your bills will be subject to a penalty co-pay of 50%, even if the services are determined to be medically necessary. Your physician is encouraged to maintain communication with Hoover Rehabilitation Services, Inc. on a regular basis as precertification requirements may change. For your convenience, the Hoover Rehabilitation Services, Inc. website, www.hooverinc.com contains Precertification requirements, or, we can be reached at 1-877-704-4440.

VOLUNTARY PRECERTIFICATION

Your physician is encouraged to participate in a *Voluntary Precertification* process by providing Hoover Rehabilitation Services, Inc. with a comprehensive treatment plan for both identified and other injuries. Hoover Rehabilitation Services, Inc. will utilize nationally-accepted criteria and the *Care Paths* to work with your physician to certify a mutually agreeable course of treatment to include itemized services and a defined treatment period. In consideration for your physician's participation in the *Voluntary Precertification* process, the bills your physician submits, when consistent with the precertified services, will be paid without utilization audit. In addition, having an approved treatment plan means that as long as treatment is consistent with the plan, additional notification to Hoover Rehabilitation Services, Inc. at Decision Points is not required. As your physician continues to participate in the *Voluntary Precertification* process for subsequent services, payment for precertified services will be made without utilization audit.

HOW TO SUBMIT DECISION POINT/PRE CERTIFICATION REQUESTS/EXTENDED TREATMENT NOTIFICATIONS

In order to complete our review, we require that your physician provide us with any past medical history that is available. We also require the diagnosis, all x-ray and other test results that may have been completed, and documentation of all treatment provided to date. We have requested that your physician indicate any tests or treatment anticipated over the next 30 days.

Your physician must utilize the enclosed "ATTENDING PROVIDER TREATMENT PLAN" form. This form must be completed, and sent to us, along with a copy of the most recent/appropriate physician progress notes, and results of diagnostic tests or studies relative to the requested services, *via mail or Fax*, (FAX Number: 570-283-1637). If you or your physician have any questions regarding this procedure, we may be reached by telephone at 1-877-704-4440.

Our review of Decision Point/Precertification requests and voluntary precertification requests will be completed within three business days of receipt of the necessary information. Requests received after 4:30 pm on a normal business day, will be considered received on the next normal business day, excluding Federal or New Jersey holidays. Notice of certification will be made to your physician's office by telephone and confirmed in writing. You will receive a copy of this notification. If we fail to notify your physician within three business days, your physician may continue with the test or treatment until a final determination is communicated to your physician. In addition, if an independent physical or mental examination is required, treatment may proceed while the exam is being scheduled and the results become available.

REVIEW OUTCOMES

- Requested service is certified.
- In the event we receive insufficient information that does not support the requested service, an **administrative denial** will be issued and will continue until we receive documentation sufficient to evaluate the request for the diagnostic test or treatment service. Once we receive sufficient documentation a decision will be communicated to you within 3 business days of receipt of the documentation.
- Any denial of reimbursement for further treatment or testing will be made by a physician or dentist.
- In the event that we must **amend** the requested services (either frequency, duration, intensity or place of service or treatment), your physician's office will be notified by telephone, with a written confirmation, and a Hoover Rehabilitation Services, Inc. physician advisor will be available to discuss the case with your physician.
- In the event we are **unable to certify** the request, your physician will be notified by telephone, with a written confirmation. A Hoover Rehabilitation Services, Inc. physician advisor will be available to discuss the case with your physician. If the request is for a surgical procedure, we will assist you to schedule a second surgical opinion, at the expense of Insurance Company.
- Pursuant to N.J.A.C. 11:3-4, et seq., as amended and your policy:
 - Failure to request 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 additional co-payment not to exceed 50% of the eligible charge for medically necessary diagnostic tests, treatments or durable medical goods that were provided between the time of notification to the insurer was required and the time that proper notification is made and the insurer has an opportunity to respond in accordance with its approved decision point review plan.

RECONSIDERATION PROCESS

If your request does not meet certification criteria, clinical rationale for this determination is available upon request. You are encouraged to utilize Hoover's internal review process

for reconsideration by contacting Hoover Rehabilitation Services, Inc. at 1-877-704-4440. We have attached both the Pre-Service Appeal Form and the Post-Service Appeal form for your convenience. The Pre-Service and Post-Service Appeal forms, along with supporting documentation should be submitted via fax, by your treating provider, to 570-283-1637. Enclosed as "Exhibit C", is detailed information regarding the Reconsideration and Appeal Process.

VOLUNTARY NETWORK SERVICES

Please note that your policy includes a voluntary Utilization Program for Prescription Drugs, Durable Medical Equipment over \$50 or rental for more than 30 days, Diagnostic Imaging including Magnetic Resonance Imaging (MRI), Computer Assisted Tomography (CAT) and electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b)1 through 3 except for needle EMGs, H-reflex and nerve conduction velocity (NCV) tests performed together by the treating physician. If an insured utilizes a conveniently located network provider for these services/tests, 30% co-pay (\$10 for prescription drugs) will be waived. Hoover Rehabilitation Services, Inc. is contracted with ALTA SERVICES, LLC, dba CHN Solutions for voluntary network services. Information regarding the availability of network providers can be found at <http://www.chnnetwork.com/volnets/> or by calling Hoover Rehabilitation Services, Inc. at 1-877-704-4440.

INDEPENDENT MEDICAL EVALUATIONS

In the event that you are requested to attend an Independent Medical Evaluation (IME), you, your physician, and your legal representative (if applicable) will be notified of the appointment via correspondence. Repeated unexcused failure to attend the scheduled IMEs may result in a termination of your benefits. If you are unable to attend the IME for any reason, you must provide at least 48 hours notice to the Nurse Case Coordinator at 1-877-704-4440. If the injured person has 2 or more unexcused failures to attend the scheduled IMEs, the injured person, their representative and all providers treating the injured person for the specified diagnosis (or related diagnosis) will be notified that no further reimbursement will be made for all future treatment, diagnostic testing or DME required for the diagnosis (or related diagnosis) contained in the Attending Physicians Treatment Plan form as a consequence for failure to comply with the plan. Failure to hand carry diagnostic films to the examination as requested will be considered an unexcused failure to attend the IME, and the examination will not be conducted.

The independent medical examination will be conducted within 7 calendar days of receipt of the request unless the claimant agrees to extend the time frame. The exam will be conducted in a location convenient to the claimant and conducted by a provider in the same discipline as the treating provider. The claimant will provide the medical records or diagnostic films to the provider conducting the examination at or before the examination.

The claimant and their treating provider will be notified of the decision whether to reimburse for further treatment, diagnostic tests, or DME within 3 business days after the examination. If the examining provider prepares a written report concerning the examination, the claimant or their designee is entitled to a copy of the report upon request.

ASSIGNMENT OF BENEFITS

Enclosed for your reference is Insurance's policy regarding "Assignment of Benefits" (Exhibit D). Please be sure your physician reads this policy information. If your physician accepts assignment for payment of benefits, be aware that he/she is required 1) to be subject to the requirements of our Decision Point Review/Precertification Plan, 2) to hold you harmless against any co-payment, caused by your physician's failure to comply with the terms of the Decision Point/Precertification Plan, and 3) agree to submit any dispute to alternate dispute resolution pursuant to N.J.A.C. 11.3-5.

The staff at Hoover Rehabilitation Services, Inc. remains available to you and your physician, to answer questions and assist with the precertification process.

Sincerely,

HOOVER REHABILITATION SERVICES, INC.
Precertification Department

Nurse Case Coordinator

Enclosures: Exhibits A, B, C, & D
Attending Physicians Treatment Plan Form
Pre-Service Appeal Form
Post Service Appeal form

CC:

CERT

CERT

Hoover Rehabilitation Services, Inc.
C/O (Insurance Co.)
(Address)
(Address)

VIA CERTIFIED & 1st CLASS MAIL

RE: **Independent Medical Examination**
Claim No.:
DOI:

Dear :

In compliance with the revised N.J. PIP Law [N.J.A.C. 11:3-4, et seq., as amended], and in following the Decision Point Review guidelines with which you were provided, Hoover Rehabilitation Services, Inc., has been requested by Insurance Company to schedule an Independent Medical Evaluation [IME] for you with .

This correspondence is being forwarded to inform you that an appointment has been scheduled for at with . Dr. 's office is located at:

Telephone No:

Should you require directions, please contact the physician's office at the above number.

It is imperative that you bring all x-ray, CT scan and MRI films relative to your injury to the appointment for the physician's review. Failure to bring the diagnostic films as requested will be considered an unexcused failure to attend the IME and the examination will not be conducted. Photo ID is also required.

If you are unable to attend this appointment for any reason, you must provide at least 48 hours notice to the Nurse Case Coordinator at 1-877-704-4440. If you require special accommodations for a disability, please notify us as soon as possible, but no later than 72 hours before the appointment.

If you have 2 or more unexcused failure to attend the exam, notification will be immediately sent to you or your designee, and all providers treating you for the diagnosis (and related diagnosis) contained in the attending physician's treatment plan form. This notification will place you and your treating providers on notice that all future treatment, diagnostic testing or durable medical equipment required for the diagnosis (or 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.

Thank you for your cooperation in this matter.

Sincerely,
HOOVER REHABILITATION SERVICES, INC.
Precertification Department

Janet DiMaria, RN, CDMS, CCM
Nurse Case Coordinator

Adj:

VIA CERTIFIED MAIL

VIA CERTIFIED MAIL

Hoover Rehabilitation Services, Inc.
C/O (Insurance Co.)
(Address)
(Address)

VIA CERTIFIED & 1st Class MAIL

**RE: Independent Medical Examination
Reschedule
Claim No.:
DOI:**

Dear _____ :

This correspondence is being forwarded to inform you that your Independent Medical Examination appointment has been re-scheduled for you on _____ at _____ with _____.
Dr. _____'s office is located at:

Telephone No:

Should you require directions, please contact the physician's office at the above number.

The Independent Medical Examination is being rescheduled for the following reason:

- You had an unexcused failure to attend the IME on _____.
- You failed to bring your diagnostic films to the IME on _____ which is considered an unexcused failure to attend the IME.
- You had an excused absence for the IME on _____.
- Other _____.

It is imperative that you bring all x-ray, CT scan and MRI films relative to your injury to the appointment for the physician's review. Failure to bring the diagnostic films as requested will be considered an unexcused failure to attend the IME and the examination will not be conducted. Photo ID is also required.

If you are unable to attend this appointment for any reason, you must provide at least 48 hours notice to the Nurse Case Coordinator at 1-877-704-4440. If you require special accommodations for a disability, please notify us as soon as possible, but no later than 72 hours before the appointment.

If you have 2 or more unexcused failures to attend the exam, notification will be immediately sent to you or your designee, and all providers treating you for the diagnosis (and related diagnosis) contained in the attending physician's treatment plan form. This notification will place you and your treating providers on notice that all future treatment, diagnostic testing or durable medical equipment required for the diagnosis (or 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.

Thank you for your cooperation in this matter.

Sincerely,
HOOVER REHABILITATION SERVICES, INC.
Precertification Department

Janet DiMaria, RN, CDMS, CCM
Nurse Case Coordinator

cc: Adjuster:

VIA CERTIFIED MAIL

VIA CERTIFIED MAIL

IME Provider:

Hoover Rehabilitation Services, Inc.
C/O (Insurance Co.)
(Address)
(Address)

VIA CERTIFIED & 1ST CLASS MAIL

RE:
Claim No.:
DOI:

Dear :

In compliance with the revised N.J. PIP Law [N.J.A.C. 11:3-4, et seq., as amended], you recently underwent an Independent Medical Evaluation [IME] to determine whether for the injuries sustained in the MVA of should be authorized or denied.

This correspondence is being forwarded to notify you of the IME physician's determination, based on a review of your medical records, x-ray films, etc., and the physical examination performed on , which indicate the following regarding the reviewed information. It was:

APPROVED:

DENIED:

will also be informed of this decision.

If you have any questions, please contact the undersigned at 1-877-704-4440.

Sincerely,
HOOVER REHABILITATION SERVICES, INC.
Precertification Department

Janet DiMaria, RN, CDMS, CCM
Nurse Case Coordinator

cc:

VIA CERTIFIED MAIL

VIA CERTIFIED MAIL

VIA CERTIFIED MAIL

Hoover Rehabilitation Services, Inc.
C/O (Insurance Co.)
(Address)
(Address)

VIA CERTIFIED & 1ST CLASS MAIL

**RE: Insured:
Injured Person:
Claim No.:
DOI:**

Dear :

In accordance with the revised N.J. PIP Law [N.J.A.C. 11:3-4, et seq., as amended], we have determined that you have not complied with the Decision Point Review Plan as follows:

- Failure to request decision point review or precertification where required per the plan.
- Failure to provide clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested.

Please be advised that Insurance Company will impose an additional 50% co-payment of the eligible charge for medically necessary diagnostic tests, treatments or durable medical goods that were provided between the time notification to the insurer was required and the time that proper notification is made and insurer has the opportunity to respond in accordance with its approved decision point review plan.

If you have any questions, please contact the undersigned at 1-877-704-4440.

Sincerely,
HOOVER REHABILITATION SERVICES, INC.
Precertification Department

Janet DiMaria, RN, CDMS, CCM
Nurse Case Coordinator

cc:

VIA CERTIFIED MAIL

VIA CERTIFIED MAIL

VIA CERTIFIED MAIL

Hoover Rehabilitation Services, Inc.
c/o **(Insurance Co.)**
 (Address)
 (Address)

NON-CERTIFICATION

CONFIDENTIAL

Copies of letters to Patient, Provider, Facility and Insurance Company:

Claimant:
Claim No:
Pre-Cert No:
ICD10:
Diagnosis:
Authorized LOS:
Date(s) of Service:

Dear Patient, Provider, Facility or Insurance Company:

Please be advised that a Decision Point Review/Pre-certification was requested by for
Treatment Plan/Service Type/Procedure:
CPT Code:

No authorization was given.

Comments:

Clinical rationale for this determination is available upon request. A reconsideration of this determination, which will allow you to speak with a Hoover Physician Advisor, may be requested by contacting Hoover's Pre-Certification Department at 1-877-704-4440. To make a demand for PIP alternate dispute resolution in accordance with N.J.A.C. 11:3-5, you may contact Forthright at 732-271-6100. Forms, rules and procedures are available on the web at <http://www.nj-no-fault.com/>.

Sincerely,
Pre-Certification Department

Medical Director

Adj

(Claimant)

(Provider)

(Attorney)

Hoover Rehabilitation Services, Inc.
C/O (Insurance Co.)
(Address)
(Address)

CERTIFICATION

CONFIDENTIAL

Copies of letters to Patient, Provider, Facility and Insurance Company:

Claimant:
Claim No:
Pre-Cert No: HP10
ICD10:
Diagnosis:
Authorized LOS:

Dear Patient, Provider, Facility or Insurance Company:

Please be advised that a Decision Point Review/Pre-certification was requested by _____ for
Treatment Plan/Service Type/Procedure:
CPT Code:

This letter will confirm Precertification on _____ .

Full authorization was given.

Sincerely,
Precertification Department

Janet DiMaria, RN, CDMS, CCM
Nurse Case Coordinator

This review applies only to the certification of medical necessity under the Personal Injury Protection coverage of the automobile insurance policy. Payment for services is made by the Insurer and is subject to the limitations of coverage contained in the policy.

Adj

Hoover Rehabilitation Services, Inc.
c/o (Insurance Co.)
(Address)
(Address)

NON-CERTIFICATION

CONFIDENTIAL

Copies of letters to Patient, Provider, Facility and Insurance Company:

Claimant:
Claim No:
ICD10:
Diagnosis:

Dear Patient, Provider, Facility or Insurance Company:

Please be advised that a Decision Point Review/Pre-certification was requested by
for

Treatment Plan/Service Type/Procedure:
CPT Code:

No authorization was provided.

To make a demand for PIP alternate dispute resolution in accordance with N.J.A.C. 11:3-5, you may contact Forthright, at 732-271-6100. Forms, rules and procedures are available on the web at <http://www.nj-no-fault.com/>.

Sincerely,
Pre-Certification Department

Nurse Case Coordinator

Adj

(Claimant)

(Provider)

(Attorney)

Hoover Rehabilitation Services, Inc.
C/O (Insurance Co.)
(Address)
(Address)

VIA CERTIFIED & 1ST CLASS MAIL

**RE: Insured:
Injured Person:
Claim No.:
DOI:**

Dear _____ :

In accordance with the revised N.J. PIP Law [N.J.A.C. 11:3-4, et seq., as amended], we have determined that you have not complied with the Decision Point Review Plan as follows:

You failed to attend the Independent Medical Evaluations [IMEs] scheduled for you with Dr. _____ on _____, and _____.

As you have had 2 or more unexcused failures to attend the scheduled IMEs, you are hereby notified that no further reimbursement will be made for all future treatment, diagnostic testing or DME required for the diagnosis (or related diagnosis) contained in the Attending Physicians Treatment Plan form as a consequence for failure to comply with the plan.

If you have any questions, please contact the undersigned at 1-877-704-4440.

Sincerely,
HOOVER REHABILITATION SERVICES, INC.
Precertification Department

Janet DiMaria, RN, CDMS, CCM
Nurse Case Coordinator

Adj

VIA CERTIFIED MAIL

VIA CERTIFIED MAIL

VIA CERTIFIED MAIL