

California Casualty and Fire Insurance Company Decision Point Review Plan

California Casualty and Fire Insurance Company has requested that Optum Managed Care Services (Optum) work with you and your physician to assure that you receive all medically necessary treatment as a result of your auto accident. These services are provided under the provisions of the NJ Auto Insurance Cost Reduction Act.

Decision Point Review/Pre-Certification and Medical Necessity

If you are injured in an automobile accident, California Casualty and Fire Insurance Company will pay, subject to your PIP benefits limits and all of the applicable California Casualty and Fire Insurance Company policy terms and conditions, all medically necessary treatment in accordance with the standards of good practice and standard professional treatment practices.

Pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance has published standard courses of treatment called "Care Paths", for soft tissue injuries of the neck and back, collectively referred to as "Identified Injuries". These Care paths provide your healthcare provider with general guidelines for treatments and diagnostic testing as to these injuries. In addition, the Care Paths require that treatment be evaluated at certain intervals called "Decision Points". At Decision Points, your healthcare provider must provide Optum information about any further treatment or test required. This is called "Decision Point Review". Care Paths and accompanying rules are available at the N.J. Department of Banking and Insurance website <http://www.nj.gov/dobi/aicrapg.htm>. The California Casualty and Fire Insurance Company Decision Point Review (DPR) Plan is available in hard copy by calling (800) 275-9485, and is also available at www.procura-inc.com.

Pre-Certification is a medical review process for specific services, tests or equipment for other than "Identified Injuries". Your medical provider must provide us information about any further treatment or testing required. The administration of any test listed in NJAC11:3-4.5(b) 1-10 requires Decision Point Review, regardless of diagnosis. The list of diagnostic tests requiring prior authorization and a list of diagnostic tests which the law prohibits us from authorizing under any circumstances are shown below. If you or your health care provider fail to submit diagnostic testing requests for Decision Point Review or fail to submit clinically supported findings that support the treatment, diagnostic testing or durable medical equipment (DME) requested, payment of your bills may be subject to a penalty co-payment of 50%, even if the services are later determined to be medically necessary.

Diagnostic Tests that are subject to Decision Point Review regardless of diagnosis

- Brain audio evoked potentials (BAEP)
- Brain evoked potentials (BEP)
- Computer assisted tomograms (CT, CAT scans)
- Dynatron/cybex station/cybex studies,
- Electroencephalogram (EEG)
- H-reflex studies
- Magnetic Resonance Imaging (MRI)
- Needle Electromyography (needle EMG)
- Nerve Conduction Velocity (NCV)
- Somatosensory Evoked Potential (SSEP)
- Sonogram/ultrasound
- Videofluoroscopy
- Visual Evoked Potential (VEP)
- Brain-mapping
- Thermogram/Thermography
- Any other diagnostic test that is subject to the requirements of Decision Point Review by New Jersey law or regulation

Personal injury protection medical expense benefits coverage shall not provide reimbursement for the following diagnostic tests, under any circumstances, pursuant to N.J.A.C. 11:3-4.5:

1. Spinal diagnostic ultrasound;
2. Iridology;
3. Reflexology;
4. Surrogate arm mentoring;
5. Surface electromyography (surface EMG);
6. Mandibular tracking and stimulation; and

7. Any other diagnostic test that is determined by New Jersey law or regulation to be ineligible for Personal Injury Protection coverage.

Services that require Pre-Certification

For treatment, diagnostic testing or DME not included in the care paths or subject to Decision Point Review, you or your health care provider are required to obtain our precertification for the following services and/or conditions listed below. If you or your providers fail to pre-certify such services, or fail to provide clinically supported findings that support the medical necessity of the treatment, services and/or condition, diagnostic tests or DME requested, payment of bills will be subject to a penalty co-payment of 50% even if the services are determined to be medically necessary. The following treatments, services and/or conditions, goods and non-medical expenses require precertification:

- Non-emergency inpatient and outpatient hospital care including the facility where the services will be rendered and any provider services associated with these services and/or care
- Non-emergency surgical procedures, performed in a hospital, freestanding surgical center, office, etc., and any provider services associated with the surgical procedure
- Outpatient care for soft tissue/disc injuries of the injured party's, neck, back and related structures not included within the diagnoses covered by the Care Path
- Computerized muscle testing
- Cat Scan w/Myelogram
- PENS/PNT
- Trigger Point Dry Needling
- Discogram
- Current perceptual testing
- Temperature gradient studies
- Work hardening
- Vax-D / DRX types devices
- Podiatry
- Audiology
- Bone Scans
- Prescriptions costing more than \$50.00
- Compound Drugs
- Drug Screening
- Schedule II, III and IV Controlled Substances, as defined by the Drug Enforcement Administration (DEA), when prescribed for more than three months
- Treatment, testing and/or DME of Temporomandibular, any oral facial disorders
- Non-emergency dental restoration
- Carpal tunnel syndrome
- Non-Emergency inpatient and outpatient psychological/psychiatric test and/or services.
- Home health care
- Skilled nursing care
- Infusion therapy
- Transportation Services costing more than \$50.00
- Any procedure that uses an unspecified CPT; CDT; DSM IV; HCPCS codes
- Durable medical equipment, (including orthotics and prosthetics), leased or purchased for more than \$75 (or the rental of which exceeds 30 days)
- Extended care and rehabilitation facilities
- Non-medical products, devices, services and activities and associated supplies, not exclusively used for medical purposes or as DME, with a cost of \$50.00 and/or monthly rental greater than thirty (30) calendar days, including but not limited to:
 1. vehicles
 2. modification to vehicles
 3. durable goods
 4. furnishings
 5. improvements or modifications to real or personal property
 6. fixtures
 7. recreational activities and trips
 8. leisure activities and trips
 9. spa/gym membership
- Physical, occupational, speech, cognitive or other restorative therapy or other body part manipulation

except that provided for "Identified Injuries" in accordance with Decision Point Review.

- All Pain Management services except as provided for in "Identified Injuries" and in accordance with Decision Point Review, including but not limited to:
 1. acupuncture
 2. nerve blocks
 3. manipulation under anesthesia
 4. anesthesia when performed in conjunction with invasive techniques
 5. radio frequency/rhyzotomy
 6. narcotics, when prescribed for more than 3 months
 7. biofeedback
 8. implantation of spinal stimulators or spinal pumps
 9. trigger point injections
 10. tens units (transcutaneous electrical nerve stimulation)
 11. PENS (Percutaneous Electrical Nerve Stimulation)

If your provider fails to request decision point review / precertification where required or fails to provide clinical findings that support the treatment, testing or DME requested a co-payment penalty of 50% will apply even if the services are determined to be medically necessary. For benefits to be reimbursed in full, treatment, testing and DME must be medically necessary.

Emergency Care and Care in the First 10 Days after an Accident

Please note that treatment in the first ten (10) days after an accident and emergency care does not require Decision Point Review and/or Pre-certification. However, for benefits to be paid in full in accordance with the terms of your policy, the treatment must be medically necessary.

Right of Provider Choice

You are entitled to seek medical treatment from any licensed provider you choose. If you should need assistance in locating a medical professional in your area, you may call 800-275-9485 and an Optum associate will be happy to provide names and contact information or access our provider lookup online at www.procura-inc.com. Optum will perform the Decision Point Review and/or Precertification review of your medical care. Your doctor and any other treatment providers must contact Optum at 800-275-9485 to discuss the treatment of your injuries related to this accident, in accordance with our decision point review/pre-certification plan. It is important that your provider assist in this process by providing all the medical information necessary for Optum to make a timely decision about your care. Within three business days of receipt of the request and clinically supported documentation, we will either approve, modify, or deny the request, ask for additional documentation, or seek an Independent Medical Examination (IME). Our findings will be confirmed in writing to you and your provider.

Initial and Periodic Notification Requirement

California Casualty and Fire Insurance Company may require that the insured advise and inform them about the injury and the claim as soon as possible after the accident and periodically thereafter. This may include the production of information regarding the facts of the accident, the nature and cause of the injury, the diagnosis and the anticipated course of treatment. If this information is not supplied as required, California Casualty and Fire Insurance Company may impose an additional co-payment penalty which shall be no greater than:

- (a) Twenty five percent (25%) when received 30 or more days after the accident; or
- (b) Fifty percent (50%) when received 60 or more days after the accident

How to submit decision point and/or precertification requests:

Decision Point / Precertification requests must be submitted directly to Optum and should be submitted by fax to (610) 631-7011.

You may also submit your requests via the web: <http://providerhub.procuranet.com> or at the following e-mail address: AIMSAdmin@optum.com.

You may also submit your requests to the following address:

Optum Managed Care Services

Optum shall provide 24 hour, 7-day / week telephone service. Regular business hours are Monday through Friday 7:30 AM to 5:00 PM EST. All requests for pre-authorization received on weekends and /or Federal and/or NJ State holidays will be handled on the next business day.

Properly Submitted Requests

Pursuant to N.J.A.C. 11:3-4.7(d), all providers must use the Attending Provider Treatment Plan (AFTP) form, to submit Decision Point Review and Precertification Requests. No other forms for this purpose are permitted. A copy of the AFTP form is available at <http://www.nj.gov/dobi/aicrapg.htm> or by contacting Optum at 800-275-9485, or at www.procura-inc.com.

A properly submitted AFTP form must be completed in its entirety. It must include the injured person's full name and birth date, the claim number, the date of the accident, diagnoses / ICD-9 or ICD-10 code(s), each CPT code requested including frequency and duration.

Properly submitted requests for decision point review and precertification must also include legible clinically supported findings that support the treatment, diagnostic test or DME requested. Clinically supported findings, supplied to Optum, must not only be legible but also establish that a health care provider, prior to selecting, performing or ordering the administration of a treatment, diagnostic testing or DME, has:

1. Personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment, diagnostic testing or DME;
2. Physically examined the patient, including making an assessment of any current and/or historical subjective complaints, observations, objective findings, neurologic indications and physical tests;
3. 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 DME; and
4. Recorded and documented these observations, positive and negative findings and conclusions on the patient's medical records.

Within three (3) business days following receipt of a properly submitted request, Optum will provide its determination. Our failure to respond within three (3) business days will allow a provider to continue treatment until we provide the required notice.

When an improperly submitted request is received, Optum will inform your treating provider what additional medical documentation or information is required. An administrative denial for failure to provide required medical documentation or information will be issued and will remain in effect until all requested information needed to properly process a review to determine medical necessity regarding the requested treatment/testing and/or DME is received. Our determination will be provided within three (3) business days following receipt of the additional required documentation or information. If we fail to notify the eligible injured party or provider of our determination within three (3) business days following receipt of the additional required documentation or information, you may continue with the test or treatment until our final determination is communicated to your provider.

Any denial of treatment or testing based on medical necessity shall be made by a physician or dentist.

PLEASE NOTE: Authorized testing, treatment and/or DME is only approved for the range of dates noted in the determination letter(s).

Expired Authorization:

If you or your treating Provider fails to follow the decision point review/precertification procedures identified in this document, any approved testing, treatment and/or DME completed after the authorization period (last date in the range of dates indicated in the authorization notice letter) expires will be subject to a penalty co-pay of 50%, even if the services are determined to be medically necessary.

Independent Medical Examinations (IME)

If the treatment or testing is not approved or we are unable to determine medical necessity, Optum may request

additional information from your physician or a physical examination may be required to determine the medical necessity of further treatment, diagnostic testing or durable medical equipment. Optum may send you to another physician in the same specialty as your physician for an independent medical examination (IME). The appointment for the physical examination shall be scheduled within seven calendar days of receipt of the notice unless the injured person agrees to extend the time period. The examination will be scheduled to occur within 30 calendar days of the receipt of the request. Examinations scheduled to occur beyond 30 calendar days of the receipt of the request, must be attended. Failure to attend an examination scheduled to occur more than thirty (30) calendar days after receipt of the request will be considered an unexcused failure to attend the examination.

Medically necessary treatment may continue while the examination is being scheduled and results become available. Only medically necessary treatment related to the motor vehicle accident will be reimbursed. If the examining provider prepares a written report concerning the examination, the eligible injured person, or his or her designee, shall be entitled to a copy of the report upon request. You will receive a letter providing this information and the information as to where to go for the scheduled examination. This examination will be scheduled at a location convenient to the injured person.

You would be required to bring a copy of your medical records and x-rays or MRI films to the appointment for the IME physician to review. Failure to provide the required medical records and/or diagnostic studies/tests will be considered an unexcused failure to attend the IME. You are required to present photo identification, or any form of identification, to the examining provider at the time of the exam. Failure to comply with this requirement will result in an unexcused failure to attend the examination.

If you are non-English speaking, then an English speaking interpreter must accompany you to the examination. No interpreter fees or costs will be compensable. Failure to comply with this requirement will result in an unexcused failure to attend the examination.

If you must reschedule your appointment, you must contact Optum at 800-275-9485 no less than three (3) business days prior to the scheduled appointment. Failure to comply with this requirement will result in an unexcused failure to attend the examination

Once the review of medical records and/or independent medical examination has been completed, you and your physician will be notified of the results within 3 business days after the examination. A copy of the examining provider's report, if completed, is available upon request.

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

The following actions constitute an unexcused failure to attend an independent examination:

- Failure to appear at a scheduled examination without providing at least 72 business hours notification of inability to attend
- Failure to attend a rescheduled examination when you have notified the scheduling IME office of inability to attend the initial examination
- Failure to provide requested medical records, and/or imaging reports\ films
- Failure to bring and provide photo identification to the examination if this results in the examination being canceled
- Failure to be accompanied by an English interpreter if the eligible injured party is non-English speaking;
- Failure to attend an examination scheduled to occur beyond 30 calendar days of the receipt of the request of additional treatment/test or service in question

Use of Voluntary Networks

Optum has a provider network that is available to you. As outlined in N.J.A.C. 11:3-4.8, the Optum Network is an approved network as part of a workers' compensation managed care organization pursuant to N.J.A.C. 11:6. The benefits of the network include ease of access, credentialed and quality providers and the fact that your penalty co-payment is waived when accessing a network provider.

In accordance with N.J.A.C. 11:3-4.8 the plan includes a voluntary network for:

1. Magnetic Resonance Imaging (MRI)
2. Computer Assisted Tomography (CT/CAT Scans)
3. Needle Electromyography (needle EMG) ** H-reflex and nerve conduction velocity (NCV) tests
4. Somatosensory Evoked Potential (SSEP)**
5. Visual Evoked Potential (VEP)**
6. Brain Audio Evoked Potential (BAEP)**
7. Brain Evoked Potential (BEP)**
8. Nerve Conduction Velocity (NCV)**
9. H reflex Study**
10. Electroencephalogram (EEG)**
11. DME with a cost or monthly rental in excess of \$50.00
12. Services, equipment or accommodations provided by an ambulatory surgery facility.

** except when performed by the treating physician in conjunction with a Needle EMG.

When any of the services listed above is authorized at any point in the decision point review or precertification or appeal process, information about accessing our voluntary network of providers is available on the websites or at the toll free numbers listed below. Those individuals who choose not to utilize the network will be assessed a penalty copayment not to exceed 30% of the eligible charge, including if the treatment is denied but subsequently approved. That penalty copayment will be the responsibility of the eligible injured party.

There is a specific network for the below specified services:

- A. Diagnostic Imaging/Electrodiagnostic Testing:
 - i. Information regarding the Optum Managed Care Services provider network is available to you at www.procura-inc.com or by calling (800) 275-9485.
- B. Durable Medical Equipment:
 - i. Information regarding the Optum Managed Care Services provider network is available to you at www.procura-inc.com or by calling (800) 275-9485.
- C. Services, equipment or accommodations provided by an ambulatory surgery facility.
 - i. Information regarding the Optum Managed Care Services provider network is available to you at www.procura-inc.com or by calling (800) 275-9485.

Information regarding our provider network is available to you at www.procura-inc.com or by calling 1-800-275-9485. Our provider network includes Optum providers as well as the Magnacare Network.

Preferred Provider Organization (PPO)

In addition, Optum makes available a Preferred Provider Organization (PPO) that includes all specialties, hospitals, outpatient and urgent care facilities. The use of a provider from our PPO is strictly voluntary and is provided as a service to you. A penalty co-payment will not be applied if you choose to select a provider outside this preferred provider network. Optum's preferred providers have facilities located throughout the state. Information regarding our PPO network is available to you at www.procura-inc.com or by calling (800) 275-9485. Our PPO Network includes Optum providers as well as the Magnacare Network.

Penalty Co-Payment

Any of the medical treatment or services that require Decision Point Review or Pre-certification that is deemed medically necessary but for which we were not provided advance notice will be subject to up to a 50% co-payment. Failure to submit clinically supported findings that support the treatment or services will also result in a 50% co-payment. This penalty co-payment is in addition to any other deductible or co-payment applicable to your policy. Of course, any treatment deemed not medically necessary would not be reimbursed under this policy. Failure to use an approved network provider for Diagnostic Imaging/Electro diagnostic Testing, DME, and services, equipment or accommodations provided by an ambulatory surgery facility will result in a 30% penalty copayment. All penalty copayments will be applied before the application of the policy copayment and deductible.

Right to Appeal - Internal Appeal Process:

The internal appeals process shall permit a health care provider who has been assigned benefits pursuant to N.J.A.C. 11:3-4.9, or has a power of attorney from the injured party, to participate in the internal appeals process for reconsideration of an adverse decision.

All internal appeals shall be filed using the form established by the Department by Order in accordance with N.J.A.C. 11:3-4.7(d). A properly submitted appeal form must be completed, including, but not limited to the minimum required fields as indicated by an asterisk (*). Further, an appeal rationale narrative is required to be included within these forms. Failure to comply with these requirements will result in an administrative denial of the appeal. The appeal form and all supporting documentation must be submitted by the health care provider to Optum at the address, fax number or website designated for appeals as follows:

Optum Managed Care Services
Attention: Appeals Dept
2500 Monroe Boulevard, Suite 100
Norristown, PA, 19403
Fax: 610-631-7011
E-mail: AIMSAdmin@optum.com
Web: <http://providerhub.procuranet.com>

There are two types of internal appeals:

1. Pre-service: Appeals of decision point review and/or precertification denials or modifications prior to the performance or issuance of the requested medical procedure, treatment, diagnostic test, other service and/or durable medical equipment (collectively known as "services")
2. Post-service: Appeals subsequent to the performance or issuance of the services

Pursuant to N.J.A.C. 11:3-4.7B (b), each issue shall only be required to receive one internal appeal review, by the insurer prior to making a request for alternate dispute resolution.

Pre-service Appeals

A pre-service appeal shall be submitted in writing to Optum no later than (30) thirty days after receipt of a written denial or modification of requested services.

A final decision will be communicated in writing to the health care provider who submitted the appeal within (14) fourteen days from the date Optum received the properly submitted appeal.

All pre-service appeals received after (30) thirty days from the date of receipt of the adverse decision notice shall be acknowledged as "Late Appeals." All pre-service appeals that are acknowledged as "Late Appeals" will not be processed. The pre-service appeal form must be completed, including, but not limited to the minimum required fields as indicated by an asterisk (*). Further, an appeal rationale narrative is required to be included within these forms. Failure to comply with this requirement will result in an administrative denial of the appeal.

If a pre-service appeal is not properly submitted within (30) thirty days from the date the provider has received notice of the adverse decision, the health care provider may submit another decision point review request for the services in accordance with the aforementioned section in this DPR Plan named "How to Submit Decision Point and/or Precertification Requests".

Post-Service Appeals

A post-service appeal shall be submitted in writing to Optum 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 post-service appeal form must be completed, including, but not limited to the minimum required fields as indicated by an asterisk (*). Further, an appeal rationale narrative is required to be included within these forms. Failure to comply with this requirement will result in an administrative denial of the appeal.

A final decision will be communicated in writing to the health care provider who submitted the appeal within (30) thirty days from the date Optum received the properly submitted appeal.

Pursuant to N.J.A.C. 11:3-5.1, any completed appeal may be submitted to Alternate Dispute Resolution. If the injured

party or healthcare provider retains counsel to represent them during the appeal process, they do so strictly at their own expense. No counsel fees or costs incurred during the appeal process shall be compensable. To the extent permitted by law, the results of said Alternate Dispute Resolution processes shall be final and binding.

Dispute Resolution Process

If there is any dispute that is not able to be resolved through the Internal Appeals Process, it may be resolved through the Personal Injury Protection Dispute Process (N.J.A.C. 11:3-5.1 et seq.). This process can be initiated by contacting the Forthright at 1-888-881-6231.

Failure to utilize the Internal Appeal Process prior to filing arbitration or litigation will invalidate an Assignment of Benefits.

Assignment of Benefits

If a provider accepts assignment of benefits from an insured, the provider is required to hold the insured harmless from any reduction in benefits caused by a failure on provider's part to follow the decision point review/pre-certification process. All assignments are subject to all requirements, duties and conditions of the patient's/insured's policy including but not limited to, pre-certification, decision point reviews, exclusions, deductibles and co-payments.

Assignment of a named insured's or injured party's rights to receive benefits for medically necessary treatment, DME tests or other services is prohibited except to a licensed health care provider who agrees to:

- a) Fully comply with the Insurer's DPR Plan, including precertification requirements,
- b) Comply with the terms and conditions of the Insurers policy
- c) Provide complete and legible medical records or other pertinent information when requested by us,
- d) Complete the "internal appeals process" which shall be a condition precedent to the filing of a demand for alternative dispute resolution for any issue related to bill payment, bill processing, Decision Point Review Request or Precertification request. Completion of the internal appeal process means timely submission of an appeal and receipt of the response prior to filing for alternate dispute resolution.
- e) Submit disputes to alternative dispute resolution pursuant to N.J.A.C. 11:3-5
- f) Submit to statements or examinations under oath as often as deemed reasonable and necessary.

For disputes on issues other than requests for decision point review and pre-certification, any treating provider who has accepted an assignment of benefits must submit a written request for appeal specifying the issues in dispute accompanied by supporting documentation at least 45 days prior to initiating arbitration or litigation.