



Kemper Services Group

INTRODUCTION

Pursuant to N.J.A.C. 11:3-4.4, medical providers are required to provide notification for certain ordered tests, or services performed on patients. This notification is provided in connection with Decision Point Review and Pre-certification.

Optum Managed Care Services (Optum) has been requested by Kemper Services Group to be the Utilization Review Organization involved with the Decision Point Review/Pre-certification process. Comprehensive Information Packets are sent to the Providers, Injured Party and Attorney if applicable.

Decision Point Review/ Treatment in the first 10 calendar days after an accident and emergency care as defined by 11:34.2 does not require Decision Point Reviews and/or Pre-certification. However, in order for benefits to be paid in full, the treatment must be medically necessary.

DECISION POINT REVIEW PROCESS

Pursuant to N.J.A.C. 11:3-4, the New Jersey Department of Banking and Insurance (The "Department") has published standard courses of treatment, **Care Paths**, for soft tissue injuries of the neck and back, collectively referred to as the **Identified Injuries**. (For a list of Identified Injuries by ICD-9 codes. See **Exhibit A**).

N.J.A.C. 11:3-4 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, providers must provide information about further treatment they intend to provide (**Decision Point Review**). ***In addition, the administration of any test listed in NJAC 11:3-4.5(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.state.nj.us/dobi/aicrapg.htm> or by calling Optum at **800-275-9485**. If a Provider fails to submit requests for **Decision Point Reviews**, or fails to provide clinically supported findings that support the treatment request, payment of submitted bills will be subject to a co-payment of 50% of the eligible charges even if the services are determined to be medically necessary. (In addition to any co-payment that applies under the policy).

The following diagnostic tests are subject to Decision Point Review:

- Needle electromyography (needle EMG)
- Somatosensory evoked potential (SSEP), visual evoked potential (VEP), brain audio evoked potential (BAEP), brain evoked potential (BEP), nerve conduction velocity (NCV) and H-reflex study.
- Electroencephalogram (EEG)
- Videofluoroscopy
- Magnetic resonance imaging (MRI)
- Computer assisted tomographic studies (CT, CAT scan)
- Dynatron/cyber station/ cybex
- Sonograms/ultrasound
- Thermography/Thermograms
- Brain mapping
- Any other diagnostic test that is subject to the requirements of the Decision Point Review plan by New Jersey law or regulation.

MANDATORY PRECERTIFICATION

If a patient does not have an Identified Injury, the Provider is required to obtain Pre-certification of all services itemized below. If the Provider fails to pre-certify such services or fails to submit clinically supported findings to support the request, payment of Provider bills will be subject to a penalty co-pay of 50%, even if the services are determined to be medically necessary.



Providers are encouraged to maintain communication with Optum on a regular basis as precertification requirements may change. For your convenience, the Optum website, www.procura-inc.com, contains the Kemper Services Group DPR / Pre-certification Plan, or, can be obtained by calling **1-800-275-9485**.

The following are services for which pre-certification is required:

- Non-emergency inpatient and outpatient hospital care and provider fees associated with these services.
- Non-emergency surgical procedures (performed in a hospital, freestanding surgery center, office etc...)
- Non-Emergency inpatient and outpatient Psychological/Psychiatric Services
- Extended care rehabilitation facilities;
- Outpatient care for soft-tissue/disc injuries of the injured person's neck, back and related structures not included within the diagnoses covered by the Care Paths;
- Physical, occupational, speech, cognitive or other restorative therapy or other therapeutic or body-part manipulation including manipulation under anesthesia except that provided for identified injuries in accordance with decision point review;
- All non emergency inpatient or outpatient psychological/psychiatric services and testing including biofeedback.
- Home health care;
- Non-emergency dental restoration;
- Treatment, testing and/or durable medical equipment for Temporomandibular disorder and / or any oral facial syndrome.
- Infusion therapy;
- Bone scans;
- Vax-D;
- Non-emergency Transportation Services costing more than \$50.00;
- Brain Mapping other than provided under Decision Point Review;
- Durable Medical Equipment including orthotics and prosthetics costing more than \$50.00
- Non medical products, devices, services and activities and associated supplies that are not exclusively used for medical purposes or as durable medical goods with a cost of \$50.00 and / or monthly rental greater than 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. Leisure or Recreational Activities or Trips
 8. Spa / Gym memberships
- CT Myelogram
- Discogram
- PENS/PNT
- Skilled Nursing / Rehabilitation Services
- Computerized muscle testing
- Trigger Point Dry Needling
- Infusion Therapy
- Current perceptual testing;
- Temperature gradient studies;
- Work hardening;
- Carpal Tunnel Syndrome;
- Podiatry;
- Audiology;
- Bone Scans.
- Non-Emergency Dental Restoration
- 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;
- Prescriptions costing more than \$50.00
- All Pain Management services except as provided for identified injuries in accordance with decision point review including but not limited to:
 1. Acupuncture
 2. Nerve Blocks
 3. Manipulation under anesthesia
 4. Anesthesia services when performed in conjunction with invasive techniques
 5. Radio Frequency / Rhizotomy
 6. Narcotics when prescribed for more than 3 months
 7. Implantation of Spinal stimulators or pumps
 8. Trigger Point Injections
 9. biofeedback
 10. tens units (transcutaneous electrical nerve stimulation)
 11. PENS (Percutaneous Electrical Nerve Stimulation)

VOLUNTARY PRE-CERTIFICATION

Providers are encouraged to participate in a Voluntary Pre-certification process by providing Optum with a comprehensive treatment plan for both identified and other injuries.

Optum will utilize nationally accepted criteria and the Care Paths to work with Providers to certify a mutually agreeable course of treatment to include itemized services and a defined treatment period. In addition, having an approved treatment plan means that as long as treatment is consistent with the approved plan, additional notification to Optum at Decision Points or for Pre-certification is not required.

HOW TO SUBMIT DECISION POINT PRE-CERTIFICATION REQUESTS

In order to complete our review, we require that the Provider present 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 anticipated in the next 30 calendar days.

Providers must submit all requests on the “**ATTENDING PROVIDER TREATMENT PLAN**” (AFTP) form in accordance with order number A04-143. A copy of this form can be found on the “DOBI” website www.nj.gov/dobi/aicrapg.htm, Optum website at <http://www.procura-inc.com/ProcuraNet.htm> or by contacting Optum at **1-800-275-9485**. Properly submitted requests must include a complete AFTP form which must contain, but is not limited to, the injured party’s full name, birth date, policy number, claim number, the date of the accident, diagnosis codes and all requested CPT codes listed that are intended to be used and frequency and duration of services for each service.

The **complete AFTP** form must be accompanied with appropriate progress notes, and results of diagnostic tests or studies relative to the requested services. It can be faxed to **1-610-631-7011**, E-mail: AIMSAdmin@optum.com or mailed to the following address: **Optum Managed Care Services 2500 Monroe Boulevard, Suite 100, Attention AIMS Dept, Norristown, PA 19403**. You may also submit your requests via the web: <https://providerhub.procuranet.com>

We encourage that any questions regarding the process be addressed by calling our Pre-certification Department at **800-275-9485** or emailing at AIMSAdmin@optum.com.

Optum shall provide 24 hours, 7-days per week telephone service. Regular business hours are Monday through Friday from 7:30 a.m. to 5:00 p.m. EST. All requests for pre-authorization received before or after business hours, on weekends and or Federal / New Jersey state holidays will be handled on the next business day.

Our review of Decision Point/Pre-certification requests and voluntary pre-certification requests will be completed within three business days of receipt of the necessary information.



Notice of our determination will be made to the Provider office by telephone and confirmed in writing. If we fail to make notification within three business days, the Provider may continue with the test or treatment until a final determination is communicated. 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.

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

If your treating Provider fails to follow the procedures listed below, all medically necessary testing, treatment and/or DME completed after the last date in the range of dates indicated in the determination letter will be subject to a penalty co-pay of 50%, even if the services are determined to be medically necessary. In order to avoid this penalty, your treating provider must follow the appropriate procedure below:

- When medically necessary care or DME is not completed within 14 calendar days from the date in which the authorization period expires, you must request an extension, in writing, to Optum and the extension request must include the supporting reason for the extension. It can be faxed to 1-610-631-7011 or mailed to the following address: Optum 2500 Monroe Boulevard, Suite 100, Attention AIMS Dept, Norristown, PA 19403 or E-mail: AIMSAdmin@optum.com.
- When medically necessary care or DME is not completed 30 or more calendar days from the date in which the authorization period expires; you must resubmit a request to Optum. The request must be submitted in writing and must include a complete APTP form which must contain, but is not limited to, the injured party's full name, birth date, policy number, claim number, the date of the accident, diagnosis codes and all requested CPT codes listed that are intended to be used and frequency and duration of services for each service. The complete APTP form must be accompanied with appropriate and current progress notes, and results of diagnostic tests or studies relative to the requested services. It can be faxed to 1-610-631-7011 or mailed to the following address: Optum 2500 Monroe Boulevard, Suite 100, Attention AIMS Dept, Norristown, PA 19403 or E-mail: AIMSAdmin@optum.com.

REVIEW OUTCOMES

- Requested service is certified / approved.
- In the event we receive insufficient information that does not support a review for the requested service, an administrative denial for failure to provide required medical documentation or information will be issued and will continue until we receive documentation and/or information sufficient to evaluate the request for the diagnostic test or treatment service. Once we receive sufficient documentation a decision will be communicated to the Provider within three business days of receipt of the documentation.
- In the event that we must modify the requested services, the Provider's office will be notified by telephone and confirmed in writing and an Optum physician advisor will be available to discuss the case with the Provider.
- In the event we are unable to certify the request, the Provider's office will be notified by telephone and confirmed in writing. An Optum physician advisor will be available to discuss the case with the Provider. If the request is for a surgical procedure, we will assist the injured person to schedule a second surgical opinion, at the expense of Kemper Services Group.

Please note, any denial of reimbursement for further treatment or testing based on medical necessity will be made by a physician or dentist.

RECONSIDERATION / Internal Appeal PROCESS Optum Managed Care Services Reconsideration / 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: <https://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.

Decision point Review/ Pre certification Penalty Co-Payments:

- Pursuant to N.J.A.C. 11:3-4, and the patient's/Insured's policy: Failure to request decision point review or pre-certification 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 of 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.
- No additional co-payment penalty will apply where we have received the required notice but failed to act in accordance with our approved decision point review plan to request further information, modify or deny reimbursement of further treatment, diagnostic tests or durable medical equipment.

VOLUNTARY NETWORK SERVICES

Currently, you have a 30% co-payment for diagnostic imaging, electrodiagnostic testing and durable medical equipment (see list below). Your copayment for prescription drugs is \$10.00:

1. Magnetic Resonance Imagery (MRI);
2. Computer Assisted Tomography (CAT);
3. Needle Electromyography (needle EMG), H-reflex and nerve conduction velocity (NCV) tests, except when performed together by the treating physician.
4. Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of \$50.00.
5. Prescription Drugs.

Eligible injured persons are encouraged, but not required, to obtain the noted service from one of the Optum Network of providers. In accordance with N.J.A.C. 11:3-4. 4 (f) failure to use an approved network will result in an additional copayment of 30% of the eligible charge.

Optum has a provider network that is available to you. As outlined in N.J.A.C. 11:3-4.8, the Optum 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 payment is waived when accessing a network provider.

Optum can recommend providers for the following:

1. Magnetic Resonance Imagery (MRI);
2. Computer Assisted Tomography (CAT);
3. Needle Electromyography (needle EMG), H-reflex and nerve conduction velocity (NCV) tests, except when performed together by the treating physician.
4. Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of \$50.00;
5. Prescription Drugs.



Tmesys will coordinate, any or all of the approved items listed in 1-5 above, with a provider you have selected within the Optum network.

Information regarding our provider network for durable medical equipment, and diagnostic testing (MRI, CAT Scan and Electrodiagnostic studies) is available to you at www.procura-inc.com or by calling 1-800-275-9485. Access to In-Network providers for prescription medication(s) is available by visiting www.workcompauto.optum.com or by simply contacting Tmesys at (877) 494-9195. Our provider network includes Optum providers as well as the Magnacare Network.

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 copayment penalty 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 **1-800-275-9485**. Our PPO Network includes Optum providers as well as the Magnacare Network.

Once testing, equipment or pharmacy is determined to be appropriate and medically necessary, Optum will notify the injured person and provider of the approval via phone and letter and will schedule the service via the appropriate network's referral process. An explanation of the network provisions of their policy will also be included in the notification.

INDEPENDENT MEDICAL EVALUATIONS

In the event that the injured person is requested to attend an Independent Medical Evaluation (IME), the provider, the injured person and their Legal Representative (if applicable) will be notified of the appointment via written and or fax correspondence. If the injured person is unable to attend the scheduled IME for any reason, he/she must provide at least 3 business days notice to Optum. **If the injured person has 2 or more unexcused failures to attend the scheduled IMEs, or three (3) failures in total to attend the scheduled exam**, the injured person, their representative and all providers treating the injured person for the specified diagnosis (and related diagnosis) will be notified that no further reimbursement will be made for all future treatment, diagnostic testing or DME required for the diagnosis (and related diagnosis) contained in the Attending Providers Treatment Plan form as a consequence for failure to comply with the plan. Treatment may proceed while the IME is being scheduled and until the results become available. In addition, **you are required to provide photo identification to the examining provider at the time of the examination. If you are non-English speaking, then an interpreter must accompany you to the examination at your expense.**

An example of the injured person's three (3) failures in total to attend the scheduled exam may include three (3) occurrences of any one of the following or three (3) occurrences of any combination of the following:

- **Failure to provide the medical records and diagnostic films before or on the day of the examination;**
- **Failure to inform Optum that you will not be attending the IME within 3 business days of the scheduled exam;**
- **Failure to present valid photo identification for the exam;**
- **Failure to be accompanied by an interpreter if the injured person is non-English speaking;**
- **Failure to present for any of the scheduled examination appointments for any reason including but not limited to rescheduling the exam.**

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

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



ASSIGNMENT OF BENEFITS

Assignment of the insured person's rights to receive benefits for medically necessary treatment, testing, durable medical equipment or prescription drugs or other services are prohibited except to a licensed health care provider who agrees to fully comply with our Decision Point Review Plan. If the provider accepts assignment or direct payment of benefits, the provider must hold harmless the insured and/or eligible injured person for any deduction or declination in benefits caused by the provider's failure to comply with the terms of the policy and the treating provider agrees to submit any disputes not resolved through the reconsideration process to Alternate Dispute Resolution Organization as provided for in N.J.A.C. 11:3-5.

Any assignment given to a provider who has failed to participate in the reconsideration/appeals process prior to submitting the dispute to Alternate Dispute Resolution shall be deemed void. The assignment is limited by statute and regulation to a licensed health care provider who complies with the restrictive language contained within the Kemper Services Group policy.



EXHIBIT A

Identified Injuries

722.0 Displacement of cervical intervertebral disc without myelopathy
722.1 Displacement of thoracic or lumbar intervertebral disc without myelopathy
722.10 Displacement of lumbar intervertebral disc without myelopathy
722.11.1 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
722.71 Intervertebral disc disorder with myelopathy, cervical region
722.72 Intervertebral disc disorder with myelopathy, thoracic region
722.73 Intervertebral disc disorder with myelopathy, lumbar region
728.0 Disorders of muscle, ligament and fascia
728.85 Spasm of muscle
739.0 Non-allopathic lesions-not elsewhere classified
739.1.1.1 Somatic dysfunction of cervical region
739.1.1.2 Somatic dysfunction of thoracic region
739.3 Somatic dysfunction of lumbar region
739.4 Somatic dysfunction of sacral region
739.8 Somatic dysfunction of rib cage
846.0 Sprains and strains of sacroiliac region
846.1 Sprains and strains of lumbosacral (joint) (ligament)
846.2 Sprains and strains of sacrospinatus (ligament)
846.3 Sprains and strains of sacrotuberous region
846.8 Sprains and strains of other specified sites of sacroiliac region
846.9 Sprains and strains, unspecified site of sacroiliac region
847.0 Sprains and strains of neck
847.1 Sprains and strains, thoracic
847.2 Sprains and strains, lumbar
847.3 Sprains and strains, sacrum
847.4 Sprains and strains, coccyx
847.9 Sprains and strains of back, unspecified site
922.3 Contusion of back
922.31 Contusion of back, excludes interscapular region
922.33 Contusion of back, interscapular region
953.0 Injury to cervical root
953.2 Injury to lumbar root
953.3 Injury to sacral root