GEICO General Insurance Company

Buffalo/New Jersey Claims, PO BOX 9515
Fredericksburg, VA 22403-9515

Date

Date Loss Reported to GEICO:

Company Name:
Claim Number:
Loss Date:
Policyholder:
Policy Number:
Driver:
Premier Prizm Acct No.:
Patient:

To Whom It May Concern,

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

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

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

The Plan Administrator is Premier Prizm Solutions LLC**.**

Mailing Instructions:

All Decision Point Review, pre-certification and internal appeals related documents are to be submitted to:

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

All other mail is to be submitted to:

GEICO
P.O.Box 9515
Fredericksburg, VA 22403
Fax Number: 516-213-1484

Submission of Treatment Plan Requests for Decision Point Review/Pre-Certification

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

Decision Point Review

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

In accordance with N.J.A.C. 11:3-4.5, the administration of any of the following diagnostic tests is subject to Decision Point Review, regardless of diagnosis:

Diagnostic Tests which are subject to Decision Point Review according to N.J.A.C. 11:3-4.5

1. Needle Electromyography (EMG)
2. Somatosensory Evoked Potential (SSEP)
3. Visual Evoked Potential (VEP)
4. Brain Audio Evoked Potential (BAEP)
5. Brain Evoked Potentials (BEP)
6. Nerve Conduction Velocity (NCV)
7. H-Reflex Studies
8. Electroencephalogram (EEG)
9. Videofluroscopy
10. Magnetic Resonance Imaging (MRI)
11. Computer Assisted Tomograms (CT, CAT Scan)
12. Dynatron/Cybex Station/Cybex Studies

13. Sonogram/Ultrasound
14. Brain Mapping
15. Thermography/Thermograms

Pre-Certification

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

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

Decision Point Review/Pre-Certification Process

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

Please note that the denial of Decision Point Review and pre-certification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist.

Voluntary Pre-Certification

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

Independent Medical Examinations

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

Premier Prizm will notify the injured party or designee and the treating provider of the scheduled physical or mental examination and of the consequences for unexcused failure to appear at two or more appointments. If the injured party has two or more unexcused failures to attend the scheduled exam, notification will be immediately sent to the injured person or his or her designee, and all the providers treating the injured person for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form. This notification will place the injured person on notice that all future treatment diagnostic testing or durable medical equipment required for the diagnosis and (related diagnosis) contained in the attending physicians treatment plan form will not be reimbursable as a consequence for failure to comply with the plan.

Voluntary Network Services

Premier Prizm has established a network of approved vendors for diagnostic imaging studies for all MRI's and CAT Scans, durable medical equipment with a cost or monthly rental over $100.00, prescription drugs and all electrodiagnostic testing, listed in N.J.A.C 11:3-4.5(b) 1-3, (unless performed in conjunction with a needle EMG by the treating provider). If the injured party utilizes one of the pre-approved networks, the 30% co-payment will be waived. If any of the electro-diagnostic tests listed in N.J.A.C. 11:3-4.5(b) are performed by the treating provider in conjunction with the needle EMG, the 30% co-payment will not apply. In cases of prescriptions, the $10.00 co-pay of GEICO General Insurance Company will be waived if obtained from one of the pre-approved networks.

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

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

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

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

Penalty Notification

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

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

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

Assignment of Benefits

As a condition of the assignment of benefits, you agree to comply with all procedures of the Decision Point Review Plan, Decision Point Review and precertification requirements (collectively, "Plan"). You also agree to initiate all Pre-certification and Decision Point Review requests as required by the Plan. In the event you fail to comply with the conditions of the Plan, and such failure results in the imposition of a copayment penalty, you will hold the patient harmless for such co-payment penalty insofar as you will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty. Failure to comply with the Decision Point Review /pre-certification Plan or the requirements to follow the Internal Appeals Process prior to filing litigation including arbitrations will void any and all prior assignment of benefits under this policy. Should you choose to retain an attorney to handle the Internal Appeals Process, you do so at your own expense. Additional conditions that also apply to you include:

a. Submission of disputes as defined in the Plan to the Internal Dispute Resolution Process set forth therein. After final determination, submission of disputes not resolved by the Internal Dispute Resolution Process to the Personal Injury Protection Dispute Resolution Process set forth in N.J.A.C. 11:3-5.
b. Submission of all disputes not subject to the Internal Dispute Resolution Process to the Personal Injury Protection Dispute Resolution Process set forth in N.J.A.C 11:3-5.

c. Submission of complete and legible medical records with clinically supported findings to support the diagnosis, the causal relationship to the motor vehicle accident and the care plan.
d. Compliance with a request by GEICO to (i.) Submit to an examination under oath, and (ii.) Provide GEICO with any other pertinent information/documentation requested.
e. Agreement not to pursue payment directly from the patient and to hold the patient harmless for any denial of coverage arising from the failure to comply with the conditions established by the Plan and under the Conditional Assignment of benefits. The Conditional Assignment of benefits may be revoked by the assignee, and the assignee shall be entitled to pursue payment from the patient, when benefits are not payable due to lack of coverage and/or violation of a policy condition by the patient.

GEICO's Conditional Assignment of Benefits is the only valid assignment of benefits. The assignee agrees that GEICO has the right to reject, terminate or revoke the GEICO conditional Assignment of Benefits. An assignment of benefits may require GEICO's written consent.

Internal Appeal Process

The Internal Appeal Process shall be utilized before filing arbitration.

All appeals concerning a Decision related to a Treatment Request

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

1. For appeals regarding a decision related to a treatment request, notification to Premier Prizm, the Plan administrator, needs to occur within 10 business days of the receipt of the decision in question. This appeal must be made in writing by fax, mail or by accessing the Internal Appeals Form on the web site, www.PremierPrizm.com, at which point further documentation can be discussed with a physician advisor.
2. This appeal must contain the treating provider's signature and the reason for the appeal. The written dispute shall include, but not limited to, copies of all supporting documentation with reason for reconsideration. A telephone conference with the Physician Advisor or the Medical Director and the treating provider is conducted within 10 business day of the receipt of the appeal. Premier Prizm's response to the appeal will be communicated to the requesting provider in writing by fax within ten business days of the receipt. An Internal Appeals Form can be accessed on web site at www.PremierPrizm.com.
3. It may be determined that an Independent Medical Examination is necessary. If this is the case, the appointment shall be scheduled within seven (7) calendar days of receipt of the appeal request unless the insured agrees to extend the time period. The examination shall be held in a location convenient to the insured with a **health care provider** of the same specialty as the treating provider.
4. Prizm's written response to the appeal will be communicated to the requesting provider By fax or mail within 10 business days of receipt of request or within 3 days following the Independent Medical Exam.

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

All appeals which do not concern a decision related to a treatment request shall be submitted to GEICO General Insurance Company as follows:

Disputes must be submitted to our Plan administrator, Premier Prizm for reconsideration. Issues not related to a request for Decision Point Review or Precertification can include, but are not limited to, bill review or payment for services. This appeal must be signed by the treating provider and submitted in writing stating the issue being disputed along with supporting documentation. Premier Prizm's written response to this appeal will be

communicated to the requesting provider by fax or mail within 10 business days of receipt of request. Appeals are to be submitted, in accordance with the plan as follows:
For any appeal or issue not related to a request for Decision Point Review or Precertification, (including but not limited to reimbursement) a treating provider who has accepted an assignment of benefits must submit a written request for Internal Appeals stating the issue in dispute along with supporting documentation at least 30 days prior to initiating arbitration. Should the assignee choose to retain an attorney to handle the Appeals Process, they do so at their own expense.

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

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

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

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

Sincerely,

Examiner, Examiner Code ____
1-800-841-3000
Claims Department

Encl: Assignment of Benefits Form

GEICO
PERSONAL INJURY PROTECTION BENEFITS

CONDITIONAL ASSIGNMENT OF BENEFITS

Policy Number: _____ **Claim Number:** _____

Patient's Name: _____ **Provider's Name:** _____

I authorize and request Government Employees Insurance Company, GEICO General Insurance Company, GEICO Indemnity Company and/or GEICO Casualty Company (collectively referred to as "GEICO") to pay directly to the above-named medical provider, the amount due to me under the terms of the above- referenced policy as a result of medical care rendered by that medical provider and all medical staff associated with the provider's office.

_____ _____
Patient's Signature or Parent/Legal Guardian Date

I have read the information contained in the GEICO informational letter concerning the Decision Point Review Plan, Decision Point Review and precertification requirements (collectively, "**Plan**") and, as a condition precedent to GEICO's acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office, to the following:

1. I (We) have fully complied and will comply with all the requirements of the Plan.
2. I (We) have complied and will comply with the terms and conditions of the GEICO policy.
3. I (We) will initiate all pre-certification review and decision point review requests as required by the Plan.
4. I (We) will submit disputes as defined in the Plan to the Internal Dispute Resolution Process set forth therein. After final determination, I (we) will submit disputes not resolved by the Internal Dispute Resolution process to the personal injury protection dispute resolution process set forth in N.J.A.C. 11:3-5.
5. I (We) will submit all disputes not subject to the Internal Dispute Resolution Process to the personal injury protection dispute resolution process set forth in N.J.A.C. 11:3-5.
6. I (We) will submit complete and legible medical records with clinically supported findings to support the diagnosis, causal relationship to the accident, and care plan.
7. I (We) will comply with a request to (i) submit to an examination under oath, and (ii) provide GEICO with any other pertinent information/documentation that it requests.
8. In the event that I (we) fail to comply with paragraphs one (1) though (6) above, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty.

I (we) agree that this assignment is the only valid assignment of benefits. I (we) agree that this assignment of benefits may require GEICO's written consent. I (we) agree that GEICO has the right to reject, terminate or revoke this assignment of benefits.

_____ Date: _____
Provider's Signature

_____ TIN Number: _____
Provider's Name (Please Print)

Provider's Address: _____
_____
_____

New Jersey Law requires the following to appear on this form:
"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

This form is accessible at http://www.geico.com/information/states/nj/personal-injury-protection/