GEICO
Precertification/ Decision Point Review Plan

Inclusive of Precertification Requirement

(For Losses Occurring On or After 10/1/2012)

GEICO
Decision Point Review Plan
and
Precertification Requirements

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, **Care Paths**, for soft tissue injuries of the neck and back, collectively referred to as the Identified Injuries. 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 the **Insured**/Eligible Injured Person or treating health care provider must provide us information about further treatment that is intended to be provided. This is called a **Decision Point Review.**

In addition, the administration of any diagnostic tests set forth in N.J.A.C. 11:3-4.5(b) is subject to **Decision Point Review** regardless of the diagnosis. The **Care Paths** and accompanying rules are available on the Department of Banking and Insurance's website at http:/www.state.nj.us/dobi/pipinfo/aicrapg.htm or by calling ISG at 877-308-6599. The Informational Letter to the Insured/Eligible Injured Person/Providers and the Decision Point Review Plan are accessible on GEICO's website at http://www.geico.com/information/states/nj/personal-injury-protection/ (scroll down to Losses Occurring On or After October 1, 2012).

We will advise the **Insured and/or Eligible Injured Person** of the care path requirements upon notification to us of a claim filed under Personal Injury Protection. The Decision Point Review requirements do not apply to treatment or diagnostic tests administered during emergency care or during the first ten (10) calendar days after the accident causing the injury, however only reasonable, medically necessary and treatment related to the motor vehicle accident will be reimbursed.

We will review the course of treatment at various intervals (**Decision Points**), unless a comprehensive treatment plan has been precertified by us. In order for us to determine if additional treatment or the administration of a test is medically necessary, the treating healthcare provider or the **Insured and/or Eligible Injured Person** must provide us with reasonable prior notice together with appropriate, legible, clinically supported findings that the anticipated treatment or test is medically necessary. In order to submit a decision point review and/or precertification request, your treating health care provider must submit a completed Attending Provider Treatment Plan (APTP) form via fax to (866) 257-2323 along with clinically supported findings that support the treatment, diagnostic tests or durable medical equipment requested. A copy of the APTP form can be found on the New Jersey Department of Banking and Insurance's website at http://www.state.nj.us/dobi/pipinfo/aicrapg.htm and at http://www.geico.com/information/states/nj/personal-injury-protection/. We will review this notice and supporting materials within three (3) business days. **Business days is defined as Monday through Friday 9 AM to 5:30 PM EST excluding Federal or New Jersey State Holidays and any time when our offices are closed due to a declared state of emergency.**

Following our review, we have the option to:

a. Recommend authorization of reimbursement for the treatment, test, durable medical equipment, prescription medication; or
b. Recommend denial of reimbursement for the treatment, test, durable medical equipment, prescription medication where the information submitted is incomplete and/or fails to provide clinically supported findings to establish medical necessity; or
c. Recommend modification/partial certification of reimbursement for the treatment, test, durable medical equipment, prescription drugs where the information submitted is incomplete and/or fails to provide clinically supported findings to establish medical necessity for the treatment plan requested; or
d. Request additional documentation from the attending providers documentation when the submitted documentation is illegible; or
e. Schedule a physical examination of the **Insured and/or Eligible Injured Person** where the notice and supporting materials are insufficient to authorize, deny, or modify reimbursement or further treatment, test, durable medical equipment or prescription medication; or
f. Advise you that the DPR/Pre-certification request cannot be processed as the request is incomplete due to the lack of, or an incomplete Attending Provider Treatment Plan which is mandated to be submitted with every DPR/Precertification request as per New Jersey Department of Banking and Insurance on the State mandated form. A submitted Attending Provider Treatment Plan is considered to be incomplete if it lacks information that is vital to determining medical necessity. A submitted Attending Provider's Treatment Plan must be signed by the attending health care provider and dated.

If we request a physical or mental examination:

a. The appointment for the examination will be scheduled within seven (7) calendar days of our receipt of the notice of additional treatment or tests, unless the **Insured and/or Eligible Injured Person** agrees to extend the time period;
b. The physical or mental examination will be conducted by a provider in the same discipline as the treating provider;
c. The examination will be conducted at a location reasonably convenient for the **Insured and/or Eligible Injured Person.** If unable to attend the examination, the **Insured and/or Eligible Injured Person** must notify ISG at (888) 701-5692, at least three (3) business days before the examination date. Failure to comply with this requirement will result in an unexcused absence.
   • Failure to attend the physical or mental examination will be excused if the Insured/Eligible Injured Person notifies ISG at least three (3) business days before the examination date of his or her inability to attend the examination. The burden is on the Insured/Eligible Injured Person to prove that proper notice was provided. Another examination will be scheduled to occur within thirty five (35) calendar days.
d. The **Insured and/or Eligible Injured Person** must, if requested, provide medical records, diagnostic imaging films, test results and other pertinent information to the examining provider conducting the examination. In addition, the **Insured and/or Eligible Injured Person** may be requested to bring prescribed electro-stimulation devices and/or supports/braces to the examination. The requested records and/or items must be provided no later than the time of the examination. Failure to comply with this requirement will be considered an unexcused absence.
e. The **Insured and/or Eligible Injured Person** must supply proper identification at the examination. A photo ID is required. Failure to supply the proper identification may constitute an incomplete IME until the proper documents are obtained. If the **Insured and/or Eligible Injured Person** is non-English speaking, then an English speaking interpreter must accompany the **Insured and/or Eligible Injured Person** 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.

f. Examinations will be scheduled to occur within thirty-five (35) calendar days of receipt of the request for additional treatment/test or service.
   - If an **Insured and/or Eligible Injured Person** has an excused failure to attend a scheduled IME and does not reschedule the IME within thirty-five (35) calendar days of the original IME date, the failure to attend the original IME will be unexcused.
   - The **Insured and/or Eligible Injured Person** must attend examinations scheduled to occur beyond thirty-five (35) calendar days of receipt of the request for additional treatment/test or service. Failure to attend an examination scheduled to occur more than thirty-five (35) calendar days after receipt of the request will be considered an unexcused absence.

g. When the IME is scheduled the **Insured and/or Eligible Injured Person** , his designee if noted, and health care provider(s) will be given notice of the examination date, time and location. We will also inform all health care providers providing treatment for the diagnosis (and related diagnoses) contained in the APTP form. The examination notice details the consequences for more than one unexcused failure to attend. If the **Insured and/or Eligible Injured Person** has two or more unexcused failures to attend a scheduled exam of the same specialty, notification will be sent to the **Insured and/or Eligible Injured Person** , his designee if noted, and all health care providers providing treatment for the diagnosis (and related diagnoses) contained in the APTP form. The notification will place the parties on notice that all future treatment, diagnostic testing, durable medical equipment and/ or prescription medication required for the diagnosis (and related diagnoses) contained in the APTP form will not be reimbursable as a consequence of failure to comply with the Plan. Except for surgery, procedures performed in ambulatory surgical centers, and invasive dental procedures, treatment may proceed while the IME is being scheduled and until the results become available. However, only medically necessary treatment related to the motor vehicle accident will be reimbursed.

Examples of the **Insured and/or Eligible Injured Person's** unexcused failures to attend the exam may include but are not limited to one of the following:

- Failure to provide the medical records, diagnostic imaging films, test results and other pertinent information and/ or items as requested, before or on the day of examination;
- Failure to reschedule the examination with three (3) or more business days;
- Failure to present valid photo identification or any form of identification at the time of the examination
- Failure to be accompanied by an English interpreter if the **Insured and/or Eligible Injured Person** is non-English speaking;
- Failure to attend an examination scheduled to occur beyond thirty-five (35) calendar days of the receipt of the request of additional treatment/test or service;
- Failure to cooperate fully with the examining physician.

We will notify the **Insured and/or Eligible Injured Person** , or his designee, and the health care provider of our decision to recommend authorization or denial of reimbursement for the treatment or test as promptly as possible, but no later than three (3) business days following the examination. The notification of our decision will be by fax or mail. Any recommendation of denial for reimbursement of further treatment / tests or service will be based on the determination of a physician or dentist. If the examining provider prepares a written report concerning the examination, the **Insured and/or Eligible Injured Person** , or his designee, shall be entitled to a copy of the report upon request. If we fail to respond to the **Insured and/or Eligible Injured Person** within three (3) business days after receiving the required notification and supporting medical documentation at a decision point, then the health care provider is permitted to continue the course of treatment until we provide the required notice.

The following is a list of specific diagnostic tests subject to Decision Point Review:

- Brain Mapping
- Brain Audio Evoked Potential (BAEP)
- Brain Evoked Potential (BEP)
- Computer Assisted Tomographic Studies (CT, CAT Scan)
- Dynatron/Cybex Station/Cybex Studies; and any range of muscle motion testing
- Video-fluoroscopy
- H-Reflex Studies
- Sonogram/Ultrasound
- Needle Electromyography (needle EMG)
- Nerve Conduction Velocity (NCV)
- Somatosensory Evoked Potential (SSEP)
- Magnetic Resonance Imaging (MRI)
- Electroencephalogram (EEG)
- Visual Evoked Potential (VEP)
- Thermogram/Thermography
- All diagnostic test identified in NJAC 11:3-4.5(b) for identified and all other injuries
- 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(a):

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

MANDATORY PRECERTIFICATION

If the **Insured and/or Eligible Injured Person** does not have an Identified Injury, we will require that the **Insured and/or Eligible Injured Person** or their health care provider request precertification for the services, treatments and procedures outlined in Exhibit A which includes, but is not limited to: diagnostic test(s), durable medical equipment, prescription supplies, or otherwise potentially covered medical expense benefits. In the event that an **Insured and/or Eligible Injured Person** is injured in an automobile accident, the **Insured and/or Eligible Injured Person** or the health care provider should contact ISG at 877-308-6599 in order to request precertification. In order to submit a decision point review and/or precertification request, your treating health care provider must submit a completed attending provider treatment plan (APTP) form via fax to 866-257-2323 along with legible and clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested. A properly submitted APTP form must be completed in its entirety and must include: the Insured/Eligible Injured Person's full name and birth date, the claim number, the date of the accident, diagnoses/ICD-9 codes or ICD-10 codes, each CPT code requested including frequency, duration, signature of the requesting physician and date of signature. A copy of the Attending Provider Treatment Plan form can be found on the New Jersey Department of Banking and Insurance website at http://www.state.nj.us/dobi/pipinfo/aicrapg.htm or on GEICO's website at http://www.geico.com/information/states/nj/personal-injury-protection/.

Precertification will not apply to treatment or diagnostic tests administered during emergency care or during the first ten (10) calendar days after the accident causing the injury; however, only medically necessary treatment and/or testing which is related to the motor vehicle accident will be reimbursed.

Our approval of requests for precertification will be based exclusively on medical necessity, as determined by using standards of good practice and standard professional treatment protocols, including, but not limited to, the medical protocols adopted in N.J.A.C. 11:3-4 recognized by the Commissioner of Banking and Insurance. Our final determination of the medical necessity of any disputed issues shall be made by a physician or dentist as appropriate for the injury and treatment contemplated. The **Insured and/or Eligible Injured Person** or their health care provider must provide us with reasonable prior notice of the anticipated services, treatments and procedures as outlined above, as well as, the appropriate clinically supported findings to facilitate timely approval. When appropriate, the health care provider may submit a **comprehensive treatment plan** for precertification.

The IME and DPR requirements and response options outlined in Decision Point Review above apply to Pre-Certification.

PENALTY/CO-PAYMENTS AND THE DECISION POINT REVIEW PROCESS

If a request for Decision Point Review or Precertification is not submitted as required, or if clinically supported findings that support the request are not supplied, payment of your bills will be subject to a penalty co-payment of fifty (50) percent even if the services are determined to be medically necessary. This co-payment is in addition to any deductible or co-payment under the Personal Injury Protection coverage.

The additional co-payment of fifty (50) percent for failure to pre-certify treatment will not apply if we have received the required notice, supporting medical documentation, and have failed to respond within three (3) business days to authorize or deny reimbursement of further treatment or tests. Our failure to respond within three business days will allow a health care provider to continue treatment until we provide the required notice.

For the purposes of the penalty/co-payments noted above and deductibles, the order of application will be applied consistently in the following manner:

1. Penalty Co-payment (if applicable)
2. Insured Deductible
3. Insured Co-payment

INITIAL AND PERIODIC NOTIFICATION REQUIREMENT

GEICO requires that the Insured/Eligible Injured Person 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, GEICO shall impose an additional co-payment as a penalty which shall be no greater than:

a) Twenty five (25) percent when received thirty (30) or more calendar days after the accident; or

b) Fifty (50) percent when received sixty (60) or more calendar days after the accident.

VOLUNTARY PRECERTIFICATION

Health care providers are encouraged to participate in a Voluntary Precertification process by providing ISG with a comprehensive treatment plan for both identified and other injuries.

ISG will utilize nationally accepted criteria and the medical protocols adopted in NJAC 11:3-4 to work with the health care provider with the intent to certify a mutually agreeable course of treatment to include itemized services and a defined treatment period.

In consideration for the health care provider's participation in the voluntary precertification process, the bills that are submitted, when consistent with the precertified services, will be paid so long as they are in accordance with the PIP medical fee schedule set forth in N.J.A.C. 11:3-29.6. In addition, having an approved comprehensive treatment plan means that as long as treatment is consistent with the agreed upon comprehensive treatment plan, additional notification to ISG is not required.

VOLUNTARY NETWORKS

ISG has established networks of pre-approved vendors that can be recommended for the provision of certain services, diagnostic tests, **electrodiagnostic tests,** durable medical equipment and/or prescription supplies. **Insured/Eligible Injured Persons** are encouraged, but not required, to obtain certain services, diagnostic tests, durable medical equipment and/or prescription supplies from one of the pre-approved vendors. If they use a pre-approved vendor from one of these networks for medically necessary goods or services, they will be fully reimbursed for those goods and services consistent with the policy. If they use a vendor that is not part of these pre-approved networks, reimbursement will be provided for medically necessary goods or services but only up to seventy (70) percent of the lesser of the following: (1) the charge or fee provided for in N.J.A.C. 11:3-29, or (2) the non-network vendor's usual, customary and reasonable charge or fee or (3) the allowable contract rate pursuant to any PPO contract.

For the purposes of the penalty/co-payments noted above and deductibles, the order of application will be applied consistently in the following manner:

1. Penalty Co-payment (if applicable)
2. Insured Deductible
3. Insured Co-payment

PPO NETWORKS – These networks include providers in all specialties, hospitals, outpatient facilities, and urgent care centers throughout the entire State of New Jersey. The Nurse Case Manager can provide the **Insured/Eligible Injured Person** with a current PPO network list. The use of these networks is strictly voluntary and the choice of health care provider is always made by the **Insured/ Eligible Injured Person** . The PPO networks are provided as a service to those persons who do not have a preferred health care provider by giving a list of recommended providers from which they may select that they may select from. A penalty co-payment will not be applied if you choose to select a health care provider outside of the available preferred provider networks.

DECISION POINT REVIEW PLAN PROCESS

The requirements for precertification only apply after the tenth (10) day following the automobile accident causing the injury. For every claim that is reported by the **Insured/ Eligible Injured Person** , a loss report is created and transmitted electronically to GEICO's claim office. A claim representative contacts the **Insured/Eligible Injured Person** , confirms coverage and reviews policy requirements. During this conversation, the claim representative explains decision point review and that precertification is required for the services, treatments and procedures outlined in Exhibit A. Our vendor, ISG will provide assistance as the **Insured/Eligible Injured Person** proceeds through their course of treatment. The **Insured/Eligible Injured Person** is provided with the toll free number to call with any questions they may have regarding the decision point review and precertification process. GEICO then transfers the loss information to ISG promptly in order to begin the precertification process.

Business days is defined as Monday through Friday 9:00 am to 5:30 pm EST/EDT,

excluding Federal or New Jersey State Holidays and any time when our offices are closed due to a declared state of emergency. ISG can be reached at 877-308-6599.

The ISG Customer Service Call Center Staff is available twenty-four (24) hours a day for the Insured/Eligible Injured Person or his designee if represented, and their health care provider, to call with any questions pertaining to the medical expense payment portion of the claim. The Customer Service Call Center Staff can be reached at 877-308-6599. During telephone consultations with a Nurse Case Manager an attempt is made by ISG to:

- Establish a detailed account of the injury without duplicating the information electronically transferred by GEICO
- Identify health care providers currently active on the case
- Provide educational assistance in regard to the Decision Point Review Plan / Precertification

Each person will have a Nurse Case Manager assigned to his/her case who can answer medical or billing questions pertaining to the claim. For all other questions concerning their claim, the **Insured/Eligible Injured Person** should contact their claim representative. After this initial consultation, if the **Insured/Eligible Injured Person** or treating health care provider calls with a question about an existing New Jersey PIP claim as it pertains to medical expense benefits, a telephone prompt within the toll free number voicemail system 877-308-6599 offers them the option to be connected directly with the Nurse Case Manager at ISG.

During the initial telephone consultation, the **Insured and/or Eligible Injured Person** is also advised of the GEICO's designated providers for diagnostic tests; MRI, CT, CAT Scan, Somatosensory Evoked Potential (SSEP), Visual Evoked Potential (VEP), Brain Audio Evoked Potential (BAEP), Brain Evoked Potential (BEP), Nerve Condition Velocity (NCV), and H-Reflex Study, Electroencephalogram (EEG), Needle Electromyography (Needle EMG) and durable medical equipment and/or prescription medication costing more than fifty dollars ($50.00). An exception from the network requirement applies for any of the electro-diagnostic tests performed in N.J.A.C. 11:3-4.5b1-3 when done in conjunction with a needle EMG performed by the treating health care provider. The designated providers are approved through a Workers Compensation Managed Care Organization.

The designated providers are as follows:

Carisk Imaging - Diagnostic and Neuro Diagnostic testing (888)-340-5850

Optum – Durable Medical Equipment and Prescriptions (800-777-3574)

DIAGNOSTIC TESTING – Atlantic Imaging Group (Atlantic) is a provider based organization that arranges for the provisions of Diagnostic Radiology Services through access to a panel of preferred providers. Atlantic is a full-service management services organization that provides network access, credentialing, compliance, utilization review and quality assurance. Currently there are 170 participants in the State of New Jersey.

DURABLE MEDICAL EQUIPMENT – Optum offers a full service program including arrangements for fittings, delivery, set-up and training. Its national network has over 4,500 providers of which 157 are in New Jersey. The Nurse Case Manager assists in this process by obtaining a prescription from the treating provider who notes specific items needed to aid the **Insured and/or Eligible Injured Person** in recovery. The Nurse Case Manager makes referrals to the DME vendor electronically. If equipment is rented, the Nurse Case Manager follows the treatment plan to determine when the **Insured and/or Eligible Injured Person** will no longer medically require the equipment. When no longer medically required, the supplying vendor will be notified to pick up the equipment.

PRESCRIPTIONS- Optum offers multiple paths for prescription drug needs. There is access to a network of over 63,000 pharmacies nationwide of which 1,939 are in New Jersey. Their website offers a pharmacy locator service utilizing a city, state and zip code search or can also be reached via telephone. The Nurse Case Manager makes referrals to the prescription vendor electronically. The **Insured and/or Eligible Injured Person** may also call a toll free customer service help desk to find participating pharmacies in their geographic area. Mail order is also available.

PPO NETWORKS – These networks include providers in all specialties, hospitals, outpatient facilities, and urgent care centers throughout the entire State of New Jersey. The Nurse Case Manager can provide the **Insured and/or Eligible Injured Person** with a current PPO network list. The use of these networks is strictly voluntary and the choice of health care provider is always made by the **Insured and/or Eligible Injured Person** . The PPO networks are provided as a service to those persons who do not have a preferred health care provider by giving a list of recommended providers from which they may select that they may select from.

Each of the above vendors has a toll free number and web site access where they can be reached. The vendors have accessibility throughout the State. The Nurse Case Manager can provide this information as requested.

All bills for medical services will be sent to GEICO, P.O. Box 9515 Fredericksburg, VA 22403, or fax to 516-213-1484. For any questions regarding billing, the provider will call GEICO at 800-301-1390 and discuss the bill with the assigned PIP adjuster OR Track the medical claim submitted to GEICO by enrolling in our online Medical Provider Claim Tracking website at:https://partners.geico.com/mpctweb. All bills for medical services rendered will be transmitted from GEICO to ISG. The bills will be scanned into the document management system and entered into the Bill Review system. The bills will be processed for payment if they match treatment authorized as indicated in the system. If any information differs, including diagnosis, CPT coding and services rendered, the bills will be referred to the Nurse Case Manager for utilization review.

Any bills for services recommended as medically necessary by utilization review will be processed for payment and sent to **GEICO** for any applicable deductible and/or co-payments. A denial by a Nurse Case Manager would warrant referral to a Physician Advisor for medical necessity review. The results of the Physician Advisor's decision will be noted on the Explanation of Benefits. In addition, any issue related to bill payment, bill processing, Decision Point Review Request or Precertification request may be submitted to the Internal Appeal Process, prior to filing a formal dispute.

Internal Appeals 3-Level Review Process

1. First Level/The Clinical Review - The title of the person performing first level clinical reviews is the Nurse Case Manager. The State of New Jersey Board of Nursing licenses all persons in the Nurse Case Manager position as either a Registered Nurse or Licensed Practical Nurse.

In the first level of review, the Nurse Case Manager will review all diagnosis codes, Current Procedural Terminology (CPT), Current Dental Terminology (CDT), DSM IV codes, or HCPCS codes against the treatment and testing recommendations.

Medical documentation will be reviewed on an ongoing basis. Required medical documentation from the treating provider must include documented results of the initial and subsequent evaluations to include an assessment of any current and/or historical subjective complaints, observations, objective findings, neurologic indications, and physical tests. All previously performed tests that relate to the injury and their subsequent results must be submitted in writing. Anticipated discharge will be reviewed to verify the established treatment date. If discharge has been extended and/or an additional request for services has been made, any additional medical information needed to complete the review will be requested within two (2) business days. If the Nurse Case Manager approves the requests, the system will be documented. Precertification authorization letters will be sent to Eligible Injured Person/Provider and attorney if noted on file the next business day. The Nurse Case Manager may request additional documentation when the attending provider's submitted documentation is illegible. If the Nurse Case Manager cannot render a decision that results in certification of the services requested, based on the documentation requested and submitted by the attending provider, the file will be routed to a Physician Advisor to review for medical necessity. The Physician Advisor will perform a Healthcare Provider Review/ Second Level Clinical Review.

2. Healthcare Provider Review/ Second Level Clinical Review - Healthcare Provider Review/ Second Level Clinical Review are conducted only by healthcare providers (As defined in N.J.A.C. 11:3-4.2) who hold a current non-restricted license to practice medicine or other healthcare professions in the state of New Jersey and are currently in active practice in New Jersey.

The Nurse Case Managers who review cases where documentation is considered to be complete, are required to refer any case that does not meet the clinical criteria to certify a treatment request to a Physician Advisor for review. The attending provider is notified of this at the time of intake. The Nurse Case Manager electronically submits a case information sheet to the Physician Advisor for assessment and medical determination. If additional documentation including: initial and subsequent evaluations to include an assessment of any current and/or historical subjective complaints, observations, objective findings, neurological indications, and physical tests are available, this is also submitted for review.

The Physician Advisor may:

a. Recommend that the clinical documentation submitted by the attending provider support the treatment request as medically necessary.

b. Recommend that the clinical documentation submitted by the attending provider does not support the treatment request as medically necessary and render an adverse determination

c. Recommend that the clinical documentation submitted by the attending provider supports a modified treatment/partial certification request as medically necessary.

The Physician Advisor may make an attempt to contact the attending physician prior to making his/her recommendation. Should the Physician Advisor render an adverse decision, the appropriate adverse decision notifications are processed and directed to the health care provider, insured/ eligible injured person and attorney, if applicable.

The Physician Advisor will complete the Healthcare Provider Review/ Second Level Clinical Review. If services are recommended as medically necessary, the Utilization Review/Bill Review System will be documented and letters to the insured/eligible injured person, treating health care provider and attorney if applicable, and will be sent the next business day. If services are recommended as not medically necessary the provider will be notified of the right to appeal the decision. A letter confirming the decision will be sent to the provider with an attachment describing the appeal process.

Internal Appeals Process

Pre-Service Appeal

Each issue shall be required to receive an internal appeal review by the insurer prior to making a request for Alternative Dispute Resolution.

A pre-service appeal is an appeal of decision point review and/or precertification denials or modification prior to performance or issuance of the requested medical procedure, treatment, diagnostic test, other service, and/or durable medical equipment and prescriptions. In order to be considered a valid pre-service appeal all the requirements listed below must be met:

1. ISG must be notified within thirty (30) calendar days after receipt of the written denial or modification of requested services.
2. An appeal must be communicated to an ISG Nurse Case Manager in writing with supporting documentation and reasons for the appeal. Submission of information identical to the initial documentation submitted in support of the initial request shall not be accepted as an appeal request.
3. The appeal must be submitted on the New Jersey PIP Pre-Service Appeal Form and all fields 1-34 must be completed in order to be considered. If either the New Jersey PIP Pre-Service Appeal Form is not submitted or if any fields on the New Jersey PIP Pre-Service Appeal Form are not completed then the Appeal will be administratively denied. In addition, the original APTP form, APTP decision/response document, and Appeal rationale narrative document must be included with the submission of the New Jersey PIP Pre-Service Appeal Form or the Pre-Service Appeal may be administratively denied.
4. Appeals must be submitted to ISG **P.O. Box 1247, Daphne, AL 36526 or faxed to 866-257-2323.**
5. Only those providers who have a valid Assignment of Benefits are permitted to file an appeal. Providers who are assigned benefits or who have a valid Proof of Assignment from the insured/eligible injured person, must make and complete an internal appeal prior to making a request for dispute resolution.
6. Filing an appeal as stated in numbers 1-5 is a condition precedent to filing through Alternative Dispute Resolution.
7. All available required information about a dispute should be submitted as part of the internal appeals process. Only with a showing of substantial good cause should additional required information not submitted as part of the internal appeals process be submitted in arbitration for the first time.

Medical necessity appeals of denial of Decision Point Review or Precertification requests must be made as a Pre-Service Appeal.

A decision shall be issued by the insurer to the provider who submitted the Pre-Service Appeal no later than fourteen (14) calendar days after receipt of the New Jersey PIP Pre-Service Appeal Form and any supporting documentation.

Post-Service Appeal

A Post-Service Appeal is an appeal made subsequent to the performance or issuance of the services.

In order to be considered a valid post-service appeal, all the requirements listed below must be met:

1. A post-service appeal shall be submitted to the ISG in writing within ninety (90) calendar days of the issuance of the decision that is being appealed and at least forty five (45) calendar days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or any other litigation against us. If a post-service appeal form is submitted outside of this period of time then it will be invalid and will not be considered.

2. The appeal must be submitted on the New Jersey PIP Post-Service Appeal Form and all fields 1-38 shall be completed. If either the New Jersey PIP Post-Service Appeal Form is not submitted or the fields are not completed then the Appeal will be administratively denied. In addition, the original bill (HCFA/UB), explanation of benefit/payment (EOB), and Appeal rationale narrative document must be included with the submission of the New Jersey PIP Post-Service Appeal Form or the Post-Service Appeal may be administratively denied.

3. An appeal must be communicated in writing with supporting documentation and reasons for the appeal. Submission of information identical to the initial documentation submitted in support of the billed services shall not be accepted as an appeal request.

4. Appeals must be submitted to ISG **P.O. Box 1247, Daphne, AL 36526 or faxed to 866-257-2323.**

5. Only those providers who have a valid Assignment of Benefits are permitted to file an appeal. Providers who are assigned benefits or who have a valid Proof of Assignment from the insured/eligible injured party must make and complete an internal appeal prior to making a request for dispute resolution.

6. Filing an appeal as stated in numbers 1-5 is a condition precedent to filing through Alternative Dispute Resolution.

7. All available required information about a dispute should be submitted as part of the internal appeals process. Only with a showing of substantial good cause should additional required information not submitted as part of the internal appeals process be submitted in arbitration for the first time.

Medical necessity appeals of denial of Decision Point Review or Precertification requests cannot be made as a Post-Service Appeal.

A decision shall be issued by the insurer to the provider who submitted the Post-Service appeal no later than thirty (30) calendar days after receipt of the New Jersey PIP Post Service Appeal Form and any supporting documentation. Any dispute which has not been submitted to the appeal process shall not be a valid part of any arbitration or litigation. Proof of a timely-filed appeal is required documentation when an Alternate Dispute Resolution demand is made.

A Standard Healthcare Provider Clinical Review Appeal (Third Level Review) will be conducted within fourteen (14) calendar days.

The Physician Advisor is available through ISG via the Nurse Case Manager by telephone at 877-308-6599 during regular business days. Business days is defined as Monday through Friday 9:00 am to 5:30 pm EST/EDT, excluding Federal or New Jersey State Holidays and any time when our offices are closed due to a declared state of emergency.

3. Healthcare Provider Clinical Review Appeal (Third Level Review): Healthcare Provider Clinical Review Appeal (Third Level Review) clinical reviews are conducted only by healthcare providers (as defined in N.J.A.C. 11:3- 4.2) who hold a current non-restricted licenses to practice medicine or other healthcare professions in the state of New Jersey and are currently in active practice in New Jersey. The physicians who perform the medical reviews at this level will also be credentialed and certified in accordance with the requirements of the State of New Jersey. A provider filing an appeal only has thirty (30) calendar days from the date he/she is notified of the adverse decision. If an appeal is not submitted as required in the Pre-Service Appeal and Post-Service Appeal sections of this Plan, it will not be considered. A Pre-Service Appeal must be communicated on a New Jersey PIP Pre-Service Appeal Form by facsimile or mailing address in writing with supporting documentation and reasons for the appeal. Submission of information identical to the initial documentation submitted in support of the initial request shall not be accepted as an appeal request. A Post- Service appeal must be communicated on a New Jersey PIP Post-Service Appeal Form and submitted to ISG P.O. Box 1247, Daphne, AL 36526 or faxed to 866-257-2323, with supporting documentation and reasons for the appeal.

Should a physician review be necessary, a specialist will be selected to perform this appeal who is medically qualified by certification, practice and training to deal specifically with the clinical issue under review. Under GEICO's Conditional Assignment of Benefits conditions, a provider who has accepted an assignment of benefits is required to utilize the Internal Appeals Process for these issues, prior to filing a demand for dispute resolution.

ASSIGNMENT OF BENEFITS

Assignment of an Insured's/Eligible Injured Person's rights to receive benefits for medically necessary treatment, durable medical equipment tests or other services is prohibited except to licensed health care providers who must agree to:

a. Fully Comply with GEICO's Decision Point Review Plan, including Precertification requirements,
b. Comply with the terms and conditions of GEICO's Family Automobile Insurance 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 Dispute Resolution for any issue related to bill payment, bill processing, Decision Point Review Request or Precertification requests. Completion of the internal appeal process means timely submission of an appeal, receipt of the response, and completion of the expiration of the forty five (45) day waiting period for post-service appeals, prior to filing for alternate dispute resolution. Except for emergency care as defined in N.JA.C. 11:3-4.2, any treatment that is the subject of the appeal that is performed prior to the receipt by the provider of the appeal decision shall invalidate the assignment of benefits.
e. Submit disputes to Dispute Resolution pursuant to N.J.A.C. 11:3-5,
f. Submit to statements and/or Examinations Under Oath as often as deemed reasonable and necessary.

Failure by the health care provider to comply with all the foregoing requirements will render any Assignment of Benefits null and void. Should the health care provider accept direct payment of benefits, the health care provider is required to hold harmless the Insured/Eligible Injured Person and GEICO for any reduction of payment for services caused by the health care provider's failure to comply with the terms of the Insured's policy and this Plan. Should the assignee choose to retain an attorney to handle the Internal Appeals Process, they do so at their own expense.

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 .

DISPUTE RESOLUTION

If there is a dispute as to any issue arising under this Decision Point Review/Precertification Plan, or in connection with any claim for Personal Injury Protection benefits, a request for the resolution of that dispute may be made by the Insured/Eligible Injured Person, GEICO, or a treating health care provider who has a valid Assignment of Benefits from the Insured or Insured/Eligible Injured Person. The request for dispute resolution may also include a request by any of these parties for review by a Medical Review Organization.

If we, GEICO, and/or any person seeking Personal Injury Protection benefits, do not agree as to the recovery of such benefits, or with any decision made or arising pursuant to this Decision Point Review/Precertification Plan, then the matter is required to be heard and can only be resolved by a dispute resolution organization pursuant to New Jersey law rather than filed in the Superior Court of New Jersey. A health care provider is required to have fully complied with all aspects of this Decision Point Review/Precertification Plan, including but not limited to having fully complied with the Internal Appeal Process, prior to filing any claim or action in dispute resolution.

a. 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.

b. Non-emergency surgical procedures performed in a hospital, freestanding surgical center, hospital outpatient surgical facility, office, etc., and any provider services associated with the surgical procedure.

c. Extended care rehabilitation facilities.

d. 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.

e. Physical, occupational, speech, cognitive, rehabilitation or other restorative therapy or therapeutic or body part manipulation including manipulation under anesthesia except that provided for Identified Injuries in accordance with Decision Point Review.

f. Non-emergency inpatient and outpatient psychological/psychiatric services/treatment and testing including biofeedback.

g. All pain management services except as provided for Identified Injuries in accordance with Decision Point Review.

h. Home health care

i. Non-Emergency Dental Restorations

j. Temporomandibular disorder; any oral facial syndrome

k. Infusion therapy

l. Bone scans

m. Vax-D/DRX type devices

n. Acupuncture

o. Durable medical equipment (including orthotics or prosthetics) with a cost or monthly rental in excess of fifty (50) dollars or rental in excess of thirty (30) calendar days

p. Brain Mapping other than provided under Decision Point Review

q. Transportation services costing more than fifty (50) dollars

r. Prescription medication costing more than fifty (50) dollars

s. Any procedure that uses an unspecified CPT; CDT; /DSM IV; HCPCS code

t. Computerized Muscle Testing

u. CAT Scan with Myelogram

v. Discogram

w. Current perceptual testing

x. Temperature gradient studies

y. Work hardening

z. Carpal Tunnel Syndrome

aa. Podiatry

bb. Audiology

cc. Non-medical products, devices, services, and activities, and associated supplies, not exclusively used for medical purposes or as durable medical goods, with a monthly rental or rental in excess of thirty (30) calendar days, including but not limited to:

   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

   j. Nutritional services

GEICO
PERSONAL INJURY PROTECTION BENEFITS
CONDITIONAL ASSIGNMENT OF BENEFITS
(For losses occurring on or after 10/1/12)

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, 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 Family Automobile Insurance Policy.
3. I (We) will initiate all Precertification 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) through (7) 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) shall be entitled to pursue payment from the patient when benefits are not payable due to a violation of a policy condition by the patient and/or when benefits are not payable due to lack of coverage.

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: _____

_____

_____

"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties." N.J.S. 17:33A-6.
This form is accessible at www.GEICO.com
http://www.geico.com/information/states/nj/personal-injury-protection

{LETTERHEAD}

INITIAL INFORMATION LETTER TO INSURED/ELIGIBLE INJURED PERSON/PROVIDERS
Sent on ISG and GEICO's Letter Head

Date:
Claim Number:
Doctor/Patient Name:
Injured Person Name:
Address Line 1:
Address Line 2:
Address Line 3:

Dear Provider/Patient:

Please read this letter carefully because it provides specific information concerning how a medical claim under Personal Injury Protection coverage will be handled, including specific requirements which you must follow in order to ensure payment for medically necessary treatment, tests, durable medical equipment and/or prescription medication that an Insured/Eligible Injured Person may incur as a result of a covered automobile accident.

INITIAL AND PERIODIC NOTIFICATION REQUIREMENT

GEICO requires that the Insured/Eligible Injured Person 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, GEICO shall impose an additional co-payment as a penalty which shall be no greater than:

a) Twenty five (25) percent when received thirty (30) or more calendar days after the accident; or

b) Fifty (50) percent when received sixty (60) or more calendar days after the accident.

FOR LOSSES OCCURRING ON OR AFTER OCTOBER 1, 2012
ISG has been selected by GEICO to implement their Plan. ISG will review treatment plan requests for Decision Point Review/Pre-Certification, perform Medical Bill Re-pricing and Audits of provider bills, coordinate Independent Medical Exams and Peer Reviews, and provide Case Management Services.

Mailing Instructions:

All Decision Point Review, Pre-certification and Internal Appeals related documents are to be submitted to :

ISG

PO Box 1247 Daphne, AL 36526

Phone Number: 877-308-6599

Fax Number: 866-257-2323

All Other mail is to be submitted to:

GEICO

P.O. Box 9515 Fredericksburg, VA 22403

Fax Number: 516-213-1484

DECISION POINT REVIEW

The New Jersey Department of Banking and Insurance has published standard courses of treatment, **Care Paths**, for soft tissue injuries of the neck and back, collectively referred to as the **Identified Injuries**. 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 the Insured/Eligible Injured Person or treating health care provider must provide us information about further treatment that is intended to be provided.

This is called a **Decision Point Review**.

In addition, the administration of any diagnostic tests set forth in N.J.A.C. 11:3-4.5(b) is subject to **Decision Point Review** regardless of the diagnosis. The **Care Paths** and accompanying rules are available on the Department of Banking and Insurance's website at http://www.state.nj.us/dobi/pipinfo/aicrapg.htm or by calling ISG at 877-308-6599. The Decision Point Review Plan and Informational Letter to the Insured/ Eligible Injured Person/Providers are accessible by accessible on GEICO's website at: http://www.geico.com/information/states/nj/personal-injury-protection/ *(scroll down to Losses Occurring On or After October 1,2012).*

The **Decision Point Review** requirements do not apply to treatment or diagnostic tests administered in an emergency situation and/or during the first (10) calendar days after the insured accident causing the injury; however, only medically necessary treatment related to the motor vehicle accident will be reimbursed.

ISG Nurse Case Managers are available during regular business days. Business days is defined as Monday through Friday 9:00am to 5:30pm EST/EDT, excluding Federal or New Jersey State Holidays and any time when our offices are closed due to a declared state of emergency. All requests for pre-authorization received outside of regular business days will be considered to have been received on the next business day. The ISG Customer Service Call Center Staff is available twenty-four (24) hours a day for the Insured/Eligible Injured Person or his designee if represented, and their health care provider, to call with any questions pertaining to the medical expense payment portion of the claim.

If the treating health care provider considers certain diagnostic testing to be medically necessary and causally related to the insured accident causing the injury, this also requires **Decision Point Review** per N.J.A.C. 11:3-4, regardless of diagnosis. The **Insured/Eligible Injured Person** or treating health care provider must notify us by supplying legible written support establishing the need for the test before we can consider authorizing it. 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 the **Insured/Eligible Injured Person** or treating health care provider fails to properly submit diagnostic testing requests for **Decision Point Review** or fails to properly submit clinically supported findings that support the treatment, diagnostic testing or durable medical equipment requested, payment of your bills may be subject to a penalty co-payment of fifty (50) percent, even if the services are later determined to be medically necessary and causally related to the insured accident causing the injury.

The following is a list of specific diagnostic tests subject to Decision Point Review:

- Brain Mapping
- Brain Audio Evoked Potential (BAEP)
- Brain Evoked Potential (BEP)
- Computer Assisted Tomographic Studies (CT, CAT Scan)
- Dynatron/Cybex Station/Cybex Studies; and any range of muscle motion testing
- Video-fluoroscopy
- H-Reflex Studies
- Sonogram/Ultrasound
- Needle Electromyography (needle EMG)
- Nerve Conduction Velocity (NCV)
- Somatosensory Evoked Potential (SSEP)
- Magnetic Resonance Imaging (MRI)

- Electroencephalogram (EEG)
- Visual Evoked Potential (VEP)
- Thermogram/Thermography
- Any other diagnostic test that is subject to the requirements of Decision Point Review by New Jersey law or regulation
- All diagnostic test identified in NJAC 11:3-4.5(b) for identified and all other injuries

These diagnostic tests must be administered in accordance with New Jersey Department of Banking and Insurance regulations which set forth the requirements for the use of diagnostic tests in the evaluation of injuries sustained in an auto accident.

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:

- Spinal diagnostic ultrasound
- Iridology
- Reflexology
- Surrogate arm mentoring
- Surface electromyography (surface EMG)
- Mandibular tracking and stimulation
- Any other diagnostic test that is determined by New Jersey law or regulation to be ineligible for Person Injury Protection coverage

MANDATORY PRECERTIFICATION

If the Insured/Eligible Injured Person does not have an Identified Injury, we require that the Insured/Eligible Injured Person or their health care provider request Precertification for the services, treatments and procedures which includes, but is not limited to: diagnostic test(s), durable medical equipment, prescription medication, or otherwise potentially covered medical expense benefits. The Insured/Eligible Injured Person or their health care provider must request Precertification by providing us with reasonable prior notice of the anticipated services, treatments and procedures as outlined above, as well as the appropriate clinically supported findings to facilitate timely approval. When appropriate, the health care provider may submit a comprehensive treatment plan for Precertification.

Precertification will not apply to treatment or diagnostic tests administered during emergency care or during the first ten (10) calendar days after the accident causing the injury; however, only medically necessary treatment and/or testing which is related to the motor vehicle accident will be reimbursed. The following treatments, services and/or conditions, goods and non-medical expenses require precertification:

a. 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
b. Non-emergency surgical procedures performed in a hospital, freestanding surgical center, hospital outpatient surgical facility, office, etc., and any provider services associated with the surgical procedure.
c. Extended care rehabilitation facilities
d. 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
e. Physical, occupational, speech, cognitive, rehabilitation or other restorative therapy or therapeutic or body part manipulation including manipulation under anesthesia except that provided for Identified Injuries in accordance with Decision Point Review
f. Non-emergency inpatient and outpatient psychological/psychiatric services/treatment and testing including biofeedback

g. All pain management services except as provided for Identified Injuries in accordance with Decision Point Review
h. Home health care
i. Non-emergency dental restorations
j. Temporomandibular disorder; any oral facial syndrome
k. Infusion therapy
l. Bone scans
m. Vax-D/DRX type devices
n. Acupuncture
o. Durable medical equipment (including orthotics or prosthetics) with a cost or monthly rental in excess of fifty (50) dollars or rental in excess of thirty (30) calendar days
p. Brain Mapping other than provided under Decision Point Review
q. Transportation services costing more than fifty (50) dollars
r. Prescription medication costing more than fifty (50) dollars
s. Any procedure that uses an unspecified CPT; CDT; /DSM IV; HCPCS code
t. Computerized muscle testing
u. CAT Scan with Myelogram
v. Discogram
w. Current perceptual testing
x. Temperature gradient studies
y. Work hardening
z. Carpal tunnel syndrome
aa. Podiatry
bb. Audiology
cc. Non-medical products, devices, services, and activities, and associated supplies, not exclusively used for medical purposes or as durable medical goods, with a monthly rental or rental in excess of thirty (30) calendar days, including but not limited to:
    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
    j. Nutritional services

If your provider fails to request Decision Point Review / Precertification where required or fails to provide clinical findings that support the treatment, testing or durable medical equipment requested a copayment 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 durable medical equipment must be medically necessary.

VOLUNTARY PRECERTIFICATION

Health care providers are encouraged to participate in a Voluntary Precertification process by providing ISG with a **comprehensive treatment plan** for both identified and other injuries.

ISG will utilize nationally accepted criteria and the Care Paths to work with the health care provider to certify mutually agreeable course of treatment to include itemized services and defined treatment periods.

In consideration for the health care provider's participation in the voluntary certification process, the bills that are submitted, when consistent with the precertified services will be paid as long as they are in accordance with the PIP medical fee schedules set forth in N.J.A.C. 11.3-29.6. Having an approved comprehensive treatment plan means that as long as treatment is consistent with the agreed upon comprehensive treatment plan, additional notification to ISG at Decision Points and for treatment, diagnostic testing, or durable medical equipment requiring Precertification is not required.

THE SUBMISSION OF DECISION POINT REVIEW, MANDATORY PRECERTIFICATION AND/OR VOLUNTARY PRECERTIFICATION REQUESTS

We will review properly submitted requests for treatment and/or testing within three (3) business days after we receive them. Proof of receipt by ISG must be provided by the submitting party at the insurer's request. A Decision Point Review and/or Mandatory or Voluntary Precertification requests is necessary for us to determine whether additional treatment or administration of a test is medically necessary. In order for us to make this determination the treating health care provider or the Insured/Eligible Injured Person must provide us with reasonable prior notice, as set forth herein, by submitting a completed Attending Provider Treatment Plan (APTP) form together with appropriate legible and clinically supported findings A copy of the APTP form can be found on the New Jersey Department of Banking and Insurance's website at http://www.state.nj.us/dobi/pipinfo/aicrapg.htm or on GEICO's website at http://www.geico.com/information/states/nj/personal-injury-protection/.

A properly submitted APTP form must be completed in its entirety and faxed directly to ISG at 866-257- 2323. It must include the Insured/Eligible Injured Person's full name and birth date, the claim number, the date of the accident, diagnoses/ICD-9 codes or ICD-10 codes, each CPT code requested including frequency, duration, signature of the requesting physician and date of signature.

Additionally, properly submitted requests for Decision Point Review and Precertification must include legible, clinically supported findings that support the treatment, diagnostic test or durable medical equipment requested. Clinically supported findings supplied to ISG 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 durable medical equipment, has:

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

We will review a fully completed and properly submitted request for treatment and/or testing within three (3) business days after receiving the request. Following our review, we have the option to:

a. Recommend authorization of reimbursement for the treatment, test, durable medical equipment and/or prescription medication; or
b. Recommend denial of reimbursement for the treatment, test, durable medical equipment, prescription medication where the information submitted is incomplete and/or fails to provide clinically supported findings to establish medical necessity; or
c. Recommend modification/partial certification of reimbursement for the treatment, test, durable medical equipment, prescription medication where the information submitted is incomplete and/or fails to provide clinically supported findings to establish medical necessity for the treatment plan requested; or
d. Request additional documentation from the attending providers when the submitted documentation is illegible; or
e. Schedule a mental or physical examination of the Insured/Eligible Injured Person where the notice and supporting materials are insufficient to authorize, deny, or modify reimbursement or further treatment, test, durable medical equipment or prescription medication; or
f. Advise you that the Decision Point Review/Precertification request cannot be processed as the request is incomplete due to the lack of, or an incomplete, APTP which is mandated to be submitted with every Decision Point Review/Precertification request as per New Jersey Department of Banking and Insurance on the State mandated form. A submitted APTP is considered to be incomplete if it lacks information that is vital to determine medical necessity. A submitted APTP must be signed by the treating health care provider of the proper specialty and dated.

Our approval of requests for treatment and/or testing will be based exclusively on medical necessity, as determined by using standards of good practice and standard professional treatment protocols, including, but not limited to, the medical protocols adopted in N.J.A.C. 11:3-4 recognized by the Commissioner of Banking and Insurance. Our final determination of medical necessity of any treatment and/or testing shall be made by a physician or dentist as appropriate for the injury and treatment contemplated.

When an improperly submitted and/or incomplete request is received, ISG will inform the treating health care provider of what additional medical documentation or information is required. An administrative denial for failure to provide required medical documentation 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, diagnostic testing and/or durable medical equipment 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 Insured/Eligible Injured Person or treating health care 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 treating health care provider. However, only medically necessary treatment related to the motor vehicle accident will be reimbursed.

Approved treatment, diagnostic testing and durable medical equipment is only approved for the range of dates noted in the determination letter. If the Insured/Eligible Injured Person and/or treating health care provider fail to follow the Decision Point Review/Precertification procedures identified in this document, any approved treatment, diagnostic testing and/or durable medical equipment completed and/or requested 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-payment of fifty (50) percent, even if the services are determined to be medically necessary.

INDEPENDENT MEDICAL EXAMINATIONS (IME)

If we request a Physical or Mental Examination:

a. The appointment will be scheduled within seven (7) calendar days of our receipt of the notice of additional treatment or tests, unless the Insured/Eligible Injured Person agrees to extend the time period;

b. The mental or physical examination will be conducted by a provider in the same discipline as the treating provider;

c. The examination will be conducted at a location reasonably convenient to the Insured/Eligible Injured Person. If unable to attend the examination, the Eligible Injured Person must notify ISG at 1-888-701-5692 at least three (3) business days before the examination date.

- Failure of the Insured/Eligible Injured Person to attend a scheduled IME without proper notice to ISG shall constitute an unexcused failure to attend a scheduled IME. The burden is on the Insured/Eligible Injured Person to prove that proper notice was provided.
- Failure of an Insured/Eligible Injured Person to attend a scheduled IME will be considered excused if the Insured/Eligible Injured Person notifies ISG at least three (3) business days prior to the IME date and reschedules the IME for a date, not to exceed thirty-five (35) calendar days from the date of the original IME.

d. The Insured/Eligible Injured Person must, if requested, provide medical records, diagnostic imaging films, test results and other pertinent information to the examining provider conducting the examination. In addition, the Insured/Eligible Injured Person may be requested to bring prescribed electro-stimulation devices and/or supports/braces to the examination. The requested records and/or items must be provided no later than the time of the examination. Failure to comply with this requirement will result in an unexcused failure to attend the IME.

e. The Insured/Eligible Injured Person must supply proper identification at the examination. A photo ID is required. Failure to supply the proper identification may constitute an incomplete IME until the proper documents are obtained. If the Insured/Eligible Injured Person is non-English speaking, then an English speaking interpreter must accompany the Insured/Eligible Injured Person to the IME. No interpreter fees or costs will be compensable. Failure to comply with this requirement will result in an unexcused failure to attend the examination.

f. Examinations will be scheduled to occur within thirty-five (35) calendar days of receipt of the request for additional treatment/test or service.

- If an Insured/Eligible Injured Person has an excused failure to attend a scheduled IME and does not reschedule the IME within thirty-five (35) calendar days of the original IME date, the failure to attend the original IME will be unexcused.

The Insured/Eligible Injured Person must attend IMEs scheduled to occur beyond thirty-five (35) calendar days of receipt of the request for additional treatment/test or service in question, must be attended. Failure to attend an IME scheduled to occur more than thirty-five (35) calendar days after receipt of the request will be considered an unexcused absence.

g. If the Insured/Eligible Injured Person has two or more unexcused failures to attend a scheduled examination of the same specialty, notification will be sent to the Insured/Eligible Injured Person, his designee if noted, and all health care providers providing treatment for the diagnosis (and related diagnoses) contained in the APTP form. The notification will place the parties on notice that all future treatment, diagnostic testing, durable medical equipment and/or prescription medication required for the diagnosis (and related diagnoses) contained in the APTP form will not be reimbursable as a consequence of failure to comply with the Plan. Except for surgery, procedures performed in ambulatory surgical centers, and invasive dental procedures, treatment that is medically, necessary and related to injuries from the motor vehicle accident in question, may proceed while the examination is being scheduled and until the results become available. However, 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 Insured/Eligible Injured Person, or his designee, shall be entitled to a copy of the report upon request.

Examples of the injured person's unexcused failures to attend the examination may include but are not limited to one of the following:

- Failure to provide the medical records and/or diagnostic films before or on the day of examination;
- Failure to reschedule the examination with three (3) or more business days;
- Failure to present valid photo identification or any form of identification at the time of the examination;
- Failure to be accompanied by an English interpreter if the Insured/Eligible Injured Party is non- English speaking;
- Failure to attend an examination scheduled to occur beyond thirty-five (35) calendar days of the receipt of the request of additional treatment/test or service in question;
- Failure to cooperate fully with the examining physician.

We will attempt to notify the health care provider and the Insured/Eligible Injured Person, or his designee, of our decision to recommend authorization or denial of reimbursement for the treatment or test as promptly as possible, but no later than three (3) business days following the examination. Any recommendation of denial for reimbursement of further treatment / tests or service will be based on the determination of a physician or dentist.

VOLUNTARY NETWORKS

ISG has established networks of pre-approved vendors that can be recommended for the provision of certain services, diagnostic tests, durable medical equipment and/or prescription medication. Insured/Eligible Injured persons are encouraged, but not required, to obtain certain services, diagnostic tests, durable medical equipment and/or prescription medication from one of the pre-approved vendors. If they use a pre-approved vendor from one of these networks for medically necessary goods or services, they will be fully reimbursed for those goods and services consistent with the policy and any applicable fee schedules. If they use a vendor that is not part of these pre-approved networks, reimbursement will be provided for medically necessary, causally related and reasonable goods or services but only up to seventy (70) percent of the lesser of the following: (1) the charge or fee provided for in N.J.A.C. 11:3-29.4, or (2) the non-network vendor's usual, customary and reasonable charge or fee. The Networks can be assessed either through a referral from the Nurse Case Manager (877-308-6599) or by contacting:

Carisk Imaging 888-340-5850 - for Diagnostic and Neuro Diagnostic

Optum 800-777-3574 - for Durable Medical Equipment and Prescriptions

The plan includes voluntary networks for:

- MRI
- CAT Scan
- Somatosensory Evoked Potential (SSEP)
- Visual Evoked Potential (VEP)
- Brain Audio Evoked Potential (BAEP)
- Brain Evoked Potential (BEP)
- Nerve Condition Velocity (NCV)
- H-Reflex Study
- Electroencephalogram (EEG)
- Needle Electromyography (Needle EMG)
- Video-fluoroscopy durable medical equipment and/or prescription medication costing more than fifty dollars ($50)

- An exception from the network requirement applies for any of the electro-diagnostic tests performed in N.J.A.C. 11:3-4.5(b) 1-3 when done in conjunction with the needle EMG performed by the treating health care provider. The designated providers are approved through Worker's Compensation Managed Care Organization.

For the purposes of the penalty/co-payments noted above and deductibles, the order of application will be applied consistently in the following manner:

1. Penalty Co-payments (If applicable)
2. Insured Deductible
3. Insured Co-payment

PPO NETWORKS

These networks include health care providers in all specialties, hospitals, outpatient facilities, and urgent care centers throughout the entire State of New Jersey. Upon request, the Nurse Case Manager can provide the Insured/Eligible Injured Person with a current PPO network list. The use of these networks is strictly voluntary and the choice of health care provider is always made by the Insured/Eligible Injured Person. The PPO networks are provided as a service to the Insured/ Eligible Injured Person. A penalty co-payment will not be applied if you choose to select a health care provider outside of the available preferred provider networks.

PENALTY/CO-PAYMENTS AND THE DECISION POINT REVIEW PROCESS

If a request for Decision Point Review or Precertification is not submitted as required, or if clinically supported findings that support the request are not supplied, payment of your bills will be subject to a penalty co-payment of fifty (50) percent even if the services are determined to be medically necessary. This co-payment is in addition to any deductible or co-payment under the Personal Injury Protection coverage.

If you do not utilize a network provider/facility to obtain those services, tests or equipment listed in the voluntary utilization review program section set forth above, payment for those services rendered will result in a co-payment of thirty (30) percent (in addition to any deductible or co-payment that applies under the policy) for medically necessary treatment, diagnostic tests and durable medical equipment. Keep in mind that treatment which is not medically necessary is not reimbursable under the terms of the policy. Any penalty reduction shall be applied prior to any other deductible or co-payment requirement.

The additional co-payment of fifty (50) percent for failure to pre-certify treatment will not apply if we have received the required notice, supporting medical documentation, and have failed to respond within three (3) business days to authorize or deny reimbursement of further treatment or tests. Our failure to respond within three (3) business days will allow a health care provider to continue treatment until we provide the required notice.

For the purposes of the penalty/co-payments noted above and deductibles, the order of application will be applied consistently in the following manner:

1. Penalty Co-payments (If applicable)
2. Insured Deductible
3. Insured Co-payment

ASSIGNMENT OF BENEFITS

Assignment of an Insured's/ Eligible Injured Person's rights to receive benefits for medically necessary treatment, durable medical equipment, tests or other services is prohibited except to licensed health care providers who must agree to:

a. Fully Comply with GEICO's Decision Point Review Plan, including Precertification requirements,
b. Comply with the terms and conditions of GEICO's Family Automobile Insurance 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 Dispute Resolution for any issue related to bill payment, bill processing, Decision Point Review Request or Precertification requests. Completion of the internal appeal process means timely submission of an appeal and receipt of the response prior to filing for alternate dispute resolution. Except for emergency care as defined in N.J.A.C. 11:3-4.2, any treatment that is the subject of the appeal that is performed prior to the receipt by the provider of the appeal decision shall invalidate the assignment of benefits.

e. Submit disputes to Dispute Resolution pursuant to N.J.A.C. 11:3-5,

f. Submit to statements and/or Examinations Under Oath as often as deemed reasonable and necessary.

Failure by the health care provider to comply with all the foregoing requirements will render any Assignment of Benefits null and void. Should the health care provider accept direct payment of benefits, the health care provider is required to hold harmless the Insured/ Eligible Injured Person and GEICO for any reduction of payment for services caused by the health care provider's failure to comply with the terms of the Insured's policy and this Plan. Should the assignee choose to retain an attorney to handle the Internal Appeals Process, they do so at their own expense.

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

"Services" is defined as performance or issuance of the requested medical procedure, treatment, diagnostic test, other service and/or durable medical equipment.

Pre-service Appeals:

A pre-service appeal is an appeal of a decision point review and/or precertification denial or modification prior to performance or issuance of the requested medical procedure, treatment, diagnostic test, or other service, and/or durable medical equipment and prescriptions.

If a health care provider disagrees with our determination related to Decision Point Review or Precertification of services, then the health care provider must submit a completed New Jersey PIP Pre-Service appeal form for reconsideration of the decision. Medical necessity appeals of denial of Decision Point Review or Precertification requests must only be made as a Pre-Service appeal. The appeal must be submitted on the New Jersey PIP Pre-Service Appeal Form and all fields 1-34 must be completed in order to be considered. If either the New Jersey PIP Pre-Service Appeal form is not submitted or if any fields on the New Jersey PIP Pre-Service Appeal form are not completed then the Appeal will be administratively denied. In addition, the original APTP form, APTP decision/response document, and Appeal rationale narrative document must be included with the submission of the New Jersey PIP Pre-Service Appeal form or the Pre-Service Appeal may be administratively denied.

To access the Internal Appeals Process, you must submit to ISG a completed New Jersey PIP Pre-Service Appeal form, with all relevant supporting documentation, no later than thirty (30) calendar days after receipt of the written denial or modification of the requested services. The New Jersey PIP Pre-Service Appeal form can be obtained at: http://www.geico.com/information/states/nj/personal-injury-protection/ *(scroll down to Losses Occurring On or After October 1, 2012).*

All pre-service appeals for reconsideration of a Decision Point Review or Precertification medical determination must include not only the basis for the appeal but also the medical criteria to support the dispute of a medical determination. Submission of information identical to the initial documentation submitted in support of the initial request shall not be accepted as a valid pre-service appeal request. A completed New Jersey PIP Pre-service Appeal form must be submitted and responded to by the carrier prior to completion of the requested services that are the subject of the appeal. If a New Jersey PIP Pre-Service Appeal form is not submitted within thirty (30) calendar days after receipt of denial or modification of the requested services then the appeal is not valid and will not be considered. A pre-service appeal must be properly filed in accordance with the terms of the DPR Plan prior to the filing of any action against GEICO relating to any pre-service issue or decision made by GEICO and the filing of a pre-service appeal shall be a condition precedent to the filing of any action against GEICO.

Consistent with the terms of the Decision Point Review plan and the Assignment of Benefits provision, a health care provider proceeding under an Assignment of Benefits must utilize the Internal Appeals Process which shall be a condition precedent to the filing of a demand of Dispute Resolution for any issue related to bill payment, bill processing, Decision Point Review or Precertification request. Performance of medical services prior to submitting a Pre-Service Appeal will invalidate the appeal and the healthcare provider's Assignment of Benefit.

All available required information about a dispute should be submitted as part of the internal appeals process. Only with a showing of substantial good cause should additional required information not submitted as part of the internal appeals process be submitted in arbitration for the first time.
All New Jersey PIP Pre-Service Appeal forms must be submitted in writing to ISG via certified mail/return receipt requested or via courier that provides proof of delivery to ISG within thirty (30) calendar days from the date of the adverse determination to: ISG P.O. Box 1247, Daphne, AL 36526; or via fax to 866-257-2323. Proof of receipt by ISG, Inc. must be provided by the disputing party at GEICO's request.

A decision on the Pre-service appeal will be completed and communicated to the provider who submitted the appeal within fourteen (14) calendar days of receipt of the properly submitted and completed New Jersey PIP Pre-Service Appeal form and receipt of any supporting documentation we may request.

Post-Service Appeals:
A Post-Service Appeal is an appeal made subsequent to the performance or issuance of the services.

The treating healthcare provider may request a post-service appeal on issues not related to a request for Decision Point Review or Precertification. These issues may include, but are not limited to, bill review or payment for services. Medical necessity appeals of denial of Decision Point Review or Precertification requests cannot be made as a post -service appeal. A post-service appeal must be properly filed in accordance with the terms of the DPR Plan prior to the filing of any action against GEICO relating to any post-service issue or decision made by GEICO and the filing of a post-service appeal shall be a condition precedent to the filing of any action against GEICO. A New Jersey PIP Post-Service Appeal form shall be submitted to the ISG in writing within ninety (90) calendar days of the issuance of the decision that is being appealed and at least forty five (45) calendar days prior to initiating alternate dispute resolution pursuant to N.J.A.C. 11:3-5 or any other litigation against us. If a New Jersey PIP Post-Service Appeal form is submitted outside of this period of time then it will be invalid and will not be considered. The appeal must be submitted on the New Jersey PIP Post-Service Appeal Form and all fields 1-38 shall be completed. If either the New Jersey PIP Post-Service Appeal Form is not submitted or the fields are not completed then the Appeal will be administratively denied. In addition, the original bill (HCFA/UB), explanation of benefit/payment (EOB), and Appeal rationale narrative document must be included with the submission of the New Jersey PIP Post-Service Appeal Form or the Post-Service Appeal may be administratively denied.

The New Jersey PIP Post-Service Appeal form can be obtained at http://www.geico.com/information/states/nj/personal-injury-protection/ *(scroll down to Losses Occurring On or After October 1, 2012)* . The completed New Jersey PIP Post-Service Appeal form must be signed by the treating healthcare provider and must include supporting documentation and reasons for the post-service appeal. A decision on the post-service appeal will be completed no later than thirty (30) calendar days after receipt of the New Jersey PIP Post- Service Appeal form and all supporting documentation. Post-service appeals must be submitted only to ISG P.O. Box 1247, Daphne, AL 36526, or faxed to 866-257-2323.

Consistent with the terms of the Decision Point Review plan and the Assignment of Benefits provision, a health care provider proceeding under an Assignment of Benefits must utilize the Internal Appeals Process which shall be a condition precedent to the filing of a demand of Dispute Resolution for any issue related to bill payment, bill processing, Decision Point Review or Precertification request. All available required information about a dispute should be submitted as part of the internal appeals process. Only with a showing of substantial good cause should additional required information not submitted as part of the internal appeals process be submitted in arbitration for the first time.

If the Insured/Eligible Injured Person and/or health care 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.

DISPUTE RESOLUTION

If there is a dispute as to any issue arising under this Decision Point Review/Precertification Plan, or in connection with any claim for Personal Injury Protection benefits, a request for the resolution of that dispute may be made by the Insured/Eligible Injured Person, GEICO, or a treating health care provider who has a valid Assignment of Benefits from the Insured or Insured/Eligible Injured Person. The request for dispute resolution may also include a request by any of these parties for review by a Medical Review Organization.

If we, GEICO, and/or any person seeking Personal Injury Protection benefits, do not agree as to the recovery of such benefits, or with any decision made or arising pursuant to this Decision Point Review/Precertification Plan, then the matter is required to be heard and can only be resolved by a dispute resolution organization pursuant to New Jersey law rather than filed in the Superior Court of New Jersey. A health care provider is required to have fully complied with all aspects of this Decision Point Review/Precertification Plan, including but not limited to having fully complied with the Internal Appeal Process, prior to filing any claim or action in dispute resolution.

Sincerely,

Examiner Code

1-800-841-3000 Ext.
Claims Department

GEICO
PERSONAL INJURY PROTECTION BENEFITS
CONDITIONAL ASSIGNMENT OF BENEFITS
(For losses occurring on or after 10/1/12)

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, 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 Family Automobile Insurance Policy.
3. I (We) will initiate all Precertification 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 Appeals 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 Appeals 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 (7) 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) shall be entitled to pursue payment from the patient, when benefits are not payable due to a violation of a policy condition by the patient and/or when benefits are not payable due to lack of coverage.

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.

_____ _____
Provider's Signature Date:

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

Provider's Address: _____

_____

_____

"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties." N.J.S. 17:33A-6.
This form is accessible at
www.geico.com/information/states/nj/personal-injury-protection/