PRIZM

DECISION POINT REVIEW PLAN REQUIREMENTS

IMPORTANT INFORMATION ABOUT YOUR PERSONAL INJURY PROTECTION MEDICAL COVERAGE AND REIMBURSEMENT

Please read this information carefully and share it with your treating health care providers.

This document serves as American Commerce Insurance Company's Decision Point Review and Pre-Certification Plan in accordance with NJAC 11:3-4.7 and NJAC 11:3-4.8.

Prizm LLC (Prizm) is a Personal Injury Protection (PIP) vendor as defined in NJAC 11:3-4.2 contracted by American Commerce Insurance Company to administer its Decision Point Review and Pre-Certification Plan. Prizm has appointed Dr. Victor Salvo as this Plan's Medical Director. He is a New Jersey licensed physician who is a Board Certified physician and actively practices in New Jersey.

In 1998 New Jersey enacted the Automobile Insurance Cost Reduction Act. As a result, obligations were established which you must satisfy for coverage of medically necessary treatment, diagnostic testing and durable medical equipment arising from injuries sustained in an automobile accident. During the course of your claim, you may be contacted by our PIP vendor, Prizm LLC, (Prizm) as it relates to obligations you have while receiving medical treatment for your injuries and any corresponding medical expenses. This contact may include, but is not limited to your obligation to attend Independent Medical Examinations. Failure to abide by the following obligations may affect the authorization for medical treatment, diagnostic testing and durable medical equipment.

American Commerce Insurance Company's Personal injury protection coverage shall provide reimbursement for all medically necessary expenses for the diagnosis and treatment of injuries sustained from a covered automobile accident up to the limits set forth in the policy and in accordance with New Jersey personal injury regulations. "Medically necessary" or "medical necessity" means that the medical treatment or diagnostic test is consistent with the clinically supported symptoms, diagnosis or indications of the injured person, and:

1. The treatment is the most appropriate level of service that is in accordance with the standards of good practice and standard professional treatment protocols consisting of evidence-based clinical guidelines/practice/treatment published in peer-reviewed journals;
2. The Care Paths in the Appendix, as applicable;

3. The treatment of the injury is not primarily for the convenience of the injured person or provider; and
4. Does not include unnecessary testing or treatment.

As they relate to this Decision Point Review Plan, “Business hours” are defined as Monday through Friday, between the hours of 8:00 AM and 5:00 PM, EST, except for federally and/or State Declared Holidays and New Jersey Declared State of Emergencies where travel is prohibited.

As it relates to this Decision Point Review Plan, the following applies when “Days” are referenced:

- “Days” means calendar days unless specifically designated as business days.
- A calendar and business day both end at the time of the close of business hours.
- In computing any period of time designated as either calendar or business days, the day from which the designated period of time begins to run shall not be included.
- The last day of a period of time designated as calendar days is to be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday or legal holiday.

Response on Decision Point Review and Precertification requests must be communicated to the treating provider no later than three business days after the submitted request. Example: A provider submits a proper request on Monday at 6:00 PM, which is 1 hour after the close of business hours at 5:00 PM. A response is due back to the treating provider no later than Friday at the close of the business hours.

Decisions on treatment appeals shall be communicated to the provider no later than 10 business days from the date the insurer receives the appeal. Example: The insurer receives the appeal by facsimile; transmission dated 3:00 P.M. on Tuesday, January 8. Day one of the 10- business day period is Wednesday, January 9. The 10th business day would be Tuesday, January 22, however there is a State of Emergency Declared in New Jersey on Tuesday January 22nd due to inclement weather. The insurer’s decision is due no later than Wednesday, January 23, providing the State of Emergency has been lifted.

No Decision Point or precertification requirements shall apply within 10 days of the injured party’s event or to treatment administered in emergency care as stated in NJAC 11:3-4.7. Such treatment shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.

If Prizm on behalf of American Commerce Insurance Company fails to respond to a request for decision point review/pre-certification three business days after the time it is received by Prizm, the treatment, testing or durable medical equipment may proceed until the American Commerce Insurance Company or Prizm notifies the provider that reimbursement for the treatment or testing is not authorized.

Informational materials for policyholders, injured parties and providers shall be on forms approved by the Commissioner as stated in NJAC 11:3-4.4. These materials will be distributed by American Commerce Insurance Company at policy issuance, renewal and upon notification of the claim. Additionally, these materials will be available at the insurer's Web Site. These materials will include:

- How to contact American Commerce Insurance Company or Prizm to submit decision point review/pre-certification requests including telephone, fax numbers, and email addresses.

- An explanation of the Decision Point Review process/Pre-Cert Process including a list of the identified injuries and the diagnostic tests (NJAC 11:3-4.5). The materials shall also include copies of the Care Paths or indicate how copies can be obtained. Additionally, the web site will include the list of voluntary networks with their telephone, fax and email addresses.

- A list of the medical services that require pre-certification.

- An explanation of the penalty co-payments imposed for the failure to submit decision point review/pre-certification requests where required or failure to provide clinically supported findings that support the treatment, diagnostic tests or durable medical goods in accordance with NJAC 11:3-4.4

- An explanation and certification of the American Commerce Insurance Company's voluntary network for certain types of testing, durable medical equipment and prescription drugs authorized by NJAC 11:3-4.4

- An explanation of the alternatives available to the provider if reimbursement for a proposed treatment or test is denied or modified, including the internal appeals process and how to use it.

- An explanation of the American Commerce Insurance Company's restriction on assignment of benefits, if any.

Decision Point Review Process and Obligations

I. Insured or injured party is obliged to notify the American Commerce Insurance Company at the time of injury. Contact information is provided to the insured by the American Commerce Insurance Company in their policy information. Once the American Commerce Insurance Company is notified of injuries, the claims handler will contact the injured party to explain the Decision Point Review/Pre-Certification process and obtain the facts surrounding the injury. The claims handler via mail forwards a notification packet to the injured party or designee and any named medical providers.

II. Provider is obliged to contact the American Commerce Insurance Company or its designated vendor, once treatment that is subject to Decision Point Review or Pre-Certification is initiated. The provider may contact Prizm by phone at 856-596-5600, by fax at 856-596-6300, electronically at Documents@Prizmllc.com or by accessing Prizm's web address at www.Prizmllc.com.

- In accordance with Order Number A04-143, all treating providers are required to submit all requests on the "Attending Provider Treatment Plan" for Decision Point Review and Precertification treatment requests. A copy of this form can be found on the NJDOBI web site www.nj.gov/dobi/aicrapg.htm or at Prizm's web site www.Prizmllc.com.
- Failure to submit a completed Decision Point Review and Precertification treatment request, including but not limited to a completed "Attending Provider Treatment Plan" and legible clinically supported record will result in the submitting provider being notified, three business days after the incomplete submission of what is needed to complete the precertification submission.
- Providers who submit Decision Point Review/Precertification are those providers who, in part, physically and personally perform evaluations of the injured persons condition. The Decision Point Review/Precertification Request must state specific treatment and set treatment goals. Prizm will not accept Decision Point Review/Precertification requests from the following providers:

    - Hospitals
    - Radiologic Facilities

- Durable Medical Equipment Companies
- Ambulatory Surgery Centers
- Registered bio-analytical laboratories;
- Licensed health maintenance organizations;
- Transportation Companies
- Suppliers of Prescription drugs/Pharmacies

If any of the above restricted providers submits a Decision Point Review/Precertification request, Prizm will respond to them no later than 3 business days after the receipt of the request informing that they are a restricted provider and instruct them that the submission must be made by the referring/treating provider.

III. A decision to the provider's request for treatment/testing /Durable Medical Equipment will be communicated 3 business days after the treatment request is received by Prizm. This decision is communicated to the requesting provider by fax or mail during business hours.

IV. Failure to request decision point review or pre-certification where required or failure to provide clinically supported findings that support the treatment, diagnostic testing or durable medical equipment requested shall result in an additional copayment of 50% of the eligible charge for such. The co-payment shall apply to the treatment, diagnostic test or durable medical equipment that was rendered between the time of required notification to Prizm and the time Prizm communicated the decision 3 business days after the receipt of the request. Such treatment, diagnostic testing or durable medical equipment shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.

V. In accordance with NJAC 11:3-4.7:

- Denials of decision point review and pre-certification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist.
- If Prizm fails to respond to the request three business days after the receipt of the necessary information, the treating provider may continue the test, course of treatment, or durable medical equipment until such time as the final determination is communicated to the provider.
- The treating provider will be notified of the decision after the stated 3 business days by fax or mail (as defined by date of postmark) as follows:

- Decisions:
    - Approved – A request for treatment/testing/Durable Medical Equipment is approved by either the Nurse or a Physician Advisor (if forwarded to a Physician Reviewer) or as a result of an Independent Medical Examination.
    - Denied - A request for treatment/testing/Durable Medical Equipment is denied either by a Physician Advisor or an Independent Medical Examiner.
    - Modified- A request for treatment/testing/Durable Medical Equipment is modified either by a Physician Advisor or an Independent Medical Examiner.
    - Administrative Denial – Failure to submit “Attending Provider Treatment Plan” or an incomplete Decision Point Review and Precertification treatment request, including but not limited to an incomplete “Attending Provider Treatment Plan” and legible clinically supported records, will result in the submitting provider being notified three business days after the incomplete submission of what is needed to complete the precertification submission. Upon receipt of the required additional information, the completed request will be reviewed and a decision will be rendered three business days after the submission.
    - Retrospective DOS – If the request for treatment/testing/Durable Medical Equipment is for a Date of Service which has already occurred, a decision of Retrospective DOS will be rendered. An additional copayment penalty 50% may be imposed on any such treatment/testing/DME determined to be clinically supported and medically necessary.
    - Pended to IME: If based on the Physician Advisor’s opinion a physical or mental examination is needed to render a decision, an appointment for an IME (of the same discipline and the most appropriate specialty related to the treating diagnoses) at a reasonably convenient location to the examinee is scheduled within 7 calendar days of the date of the request. It is noted that medically necessary treatment can continue while the IME is being scheduled. Such treatment shall be subject to retrospective review as the above provision

shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.

- Restricted - Provider prohibited from submitting Decision Point Review/Precertification. Provider will be instructed that the submission must be made by the referring/treating provider.

    - Previously Requested - If the requested treatment/testing/Durable Medical Equipment has already been requested by the same provider (DOS and CPT codes) or an ancillary provider (related CPT codes to primary procedure i.e., anesthesia for surgery,) a decision of previously requested will be entered and the decision of the previously requested service will be forwarded to the provider submitting the request.

- If Prizm, on behalf of the insurer, does not respond to the request within 3 business days of receipt of the necessary information, the provider may proceed with the treatment, test, or durable medical equipment until such time as a final determination is communicated to the provider.
- Prizm shall notify the injured person or designee if a physical examination is required to determine the medical necessity of further treatment, test, or durable medical equipment.
    - If, based on the Physician Advisor's opinion that a physical or mental examination is needed to render a decision, an appointment for an IME (of the same discipline and within a location reasonably convenient to the patient) is scheduled within 7 calendar days of the date of the request. It is noted that medically necessary treatment can continue while the IME is being scheduled.
    - Prizm, on behalf of American Commerce Insurance Company, shall notify by mail the injured person or his designee and shall notify by fax the requesting provider whether reimbursement for further treatment or test is authorized as promptly as possible, but no later than 3 business days after the examination.
    - The injured person, upon the request of American Commerce Insurance Company and/or Prizm shall provide medical records and other pertinent information to the provider conducting the medical examination. The requested records shall be provided at the time of the examination or before.

- If the injured party being examined does not speak English, they must contact American Commerce Insurance Company who may be able to arrange English Speaking Interpreter provided to them. They can also provide their own Interpreter at their own cost.
- Treatment may continue with the treating provider until the results of the IME are available, however only medically necessary care will be reimbursed. Such treatment shall be subject to retrospective review as the above provision shall not be construed as to require reimbursement of tests and treatment that are not medically necessary.

- Prizm shall notify the treating provider whether reimbursement for further treatment or testing is authorized as promptly as possible, but no later than 3 business days after the examination. The injured party/designee and the treating provider shall be entitled to a copy of the IME report upon request.

Unexcused Failure to Attend a Scheduled Physical EXAM

- After an unexcused failure to attend a scheduled physical exam, the American Commerce Insurance Company will send a notification (by mail or fax) to the insured or their designee and all treating providers for the diagnosis (and related diagnosis) contained in the Attending Provider Treatment Plan form advising them of the consequences (cessation of reimbursement for future treatment/tests/durable medical equipment) for unexcused failure to attend the second scheduled examination.

- Prizm will notify the injured party or designee and the treating provider of a scheduled physical examination and of the consequences for unexcused failure to appear at two or more appointments. If the injured party has two or more unexcused failures to attend the scheduled exam, notification will be sent to the injured person or his or her designee, and all the providers treating the injured person for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form. This notification will place the injured person on notice that all future treatment diagnostic testing or durable medical equipment required for the diagnosis and (related diagnosis) contained in the attending physicians treatment plan form will not be reimbursable as a consequence for failure to comply with the plan.
- The following will constitute an unexcused failure:
  - Failure of the Injured Party to attend a scheduled IME without proper notice to Prizm.

- Failure of the injured party to notify Prizm at least two (2) days prior to the IME date.
- Any reschedule of an unattended IME that exceeds thirty-five (35) calendar days from the date of the original IME, without permission from American Commerce Insurance Company.
- Failure to provide requested medical records, including radiology films, at the time of the IME.
- Failure to provide adequate proof of identification.
- If the injured party being examined does not speak English and they fail to request or provide an English Speaking Interpreter for the exam.

- American Commerce Insurance Company will notify the treating provider by fax or mail if the injured party has a second unexcused failure to attend the IME. This notification will state no further reimbursement can be made.

DECISION POINT REVIEW/PRECERTIFICATION REQUESTS

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

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

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

2. The following list includes treatment, test and medical services that are subject to Pre-Certification according to Prizm's Plan:

    - Non-emergency inpatient and outpatient hospital care
    - Non-emergency surgical procedures
    - Infusion Therapy
    - Extended Care Rehabilitation Facilities
    - All 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 Path's.
    - All Physical, Occupational, Speech, Cognitive, Rehabilitation or other restorative therapy or therapeutic or body part manipulation except that provided for identified injuries in accordance with decision point review.
    - All Outpatient psychological/psychiatric treatment/testing and/or services
    - All pain management/pain medicine services except as provided for identified injuries in accordance with decision point review
    - Home Health Care
    - Acupuncture
    - Durable Medical Equipment (including orthotics and prosthetics), with a cost or monthly rental, in excess of $100.00
    - Non-Emergency Dental Restorations
    - Temporo-mandibular disorders; any oral facial syndrome
    - Current Perception Testing
    - Computerized Muscle Testing
    - Nutritional Supplements
    - All treatment and testing related to balance disorders
    - Bone Scans
    - Podiatry
    - Any all procedures that use an unspecified CPT/CDT, DSM IV, and/or HCPC code

Treating providers are encouraged to submit their requests in an effort to establish an agreed upon voluntary comprehensive treatment plan for all of a covered person's injuries to minimize the need for piecemeal review. Reimbursement for treatment, testing or Durable Medical Equipment consistent with the consensual treatment plan will be made without review or audit.

American Commerce Insurance Company shall not retrospectively deny payment for treatment, diagnostic testing or durable medical equipment on the basis of medical necessity where a decision point review or precertification request for that treatment or testing was properly submitted to the insurer unless the request involved fraud or misrepresentation by the provider or the person receiving the treatment, diagnostic testing or durable medical equipment.

New Jersey Personal Injury Protection Law prohibits coverage for the following tests;

1. Spinal diagnostic ultrasound;
2. Iridology;
3. Reflexology;
4. Surrogate arm mentoring;
5. Surface electromyography (surface EMG);
6. Mandibular tracking and stimulation;
7. Any other diagnostic tests that is determined by New Jersey Law or regulation to ineligible for Personal Injury Protection Coverage.

New Jersey Personal Injury Protection Law prohibits reimbursement for the following treatment:

1) Kinesio Tape;
2) X-ray Digitization; or
3) Any other treatment/test tests that is determined by New Jersey Law or regulation to ineligible for Personal Injury Protection Reimbursement.

Pursuant to N.J.A.C. 13:30-8.22(b), the personal injury protection medical expense coverage shall not provide reimbursement for the following diagnostic tests which have been identified by the New Jersey State Board of Dentistry as failing to yield data of sufficient volume to alter or influence the diagnosis or treatment plan employed to treat TMJ/D:

1. Mandibular tracking;
2. Surface EMG;
3. Sonography;
4. Doppler ultrasound;
5. Needle EMG;
6. Electroencephalogram (EEG);
7. Thermograms/thermographs;
8. Video fluoroscopy; and
9. Reflexology.

Any other treatment/test tests that is determined by New Jersey Law or regulation to ineligible for Personal Injury Protection Reimbursement.

1. In accordance with NJAC 11:3-4.7, Prizm's Appeal Process is as follows:
    - If a request for medical services is denied or modified by a Physician Advisor Review or an IME, the treating provider can request a reconsideration of the physician recommendation. This request must be made in writing within 10 business days of the issuance of the recommendation of the DPR or Pre-Certification request. The request must include the appealing physician's signature and reasons for reconsideration along with any additional supporting documentation.

    It may be determined that an Independent Medical Examination is necessary. If this is the case, the appointment shall be scheduled within seven (7) calendar days of receipt of the appeal request unless the injured person agrees to extend the time period. The examination shall be scheduled with a provider of the same discipline and within a location reasonably convenient to the patient.

    - Prizm's written response to the appeal will be communicated to the requesting provider by fax or mail within 10 business days after receipt of request.
    - If the appeal is for any issue not related to a request for a decision point review or precertification request, a treating provider may request reconsideration through Prizm. Issues not related to a request for decision point review or precertification can include, but are not limited to, bill review or payment for services. This appeal must be signed by the treating provider and submitted in writing stating the issue being disputed along with supporting documentation within 30 (thirty) days of the issuance of the decision that is the subject of the appeal. Prizm's written response to this appeal will be communicated to the requesting provider by fax or mail 10 business days after the receipt of request

    - If the treating provider is not satisfied with the results of Prizm's Internal Appeals Process, the treating provider may file with the Dispute Resolution Administrator governed by regulations promulgated by the New Jersey Department of Banking and Insurance (N.J.A.C. 11:3-5) and can be initiated by contacting the Forthright at 732-271-6100 or toll-free at 1-888-881-6231. Information is also available on the Forthright website, http://www.nj-no-fault.com. American Commerce Insurance Company retains the right to file a Motion to Dismiss any PIP dispute that may be filed in Superior Court. The failure to utilize the Appeals Process prior to filing arbitration or litigation will invalidate an assignment of benefits.

Assignment of Benefits – If the provider accepts assignment for payment of benefits please be aware that the provider is required to hold harmless the insured and the insurer for any reduction of benefits caused by the treating provider's failure to comply with the terms of Decision Point Review/Pre-Certification Plan. The appeal processes as listed above, must be followed by any provider who has accepted an assignment of benefits. A treating provider must agree to submit appeals for all issues (both those related to the medical decision as rendered during the Decision Point Review/ PreCertification Process and to all others including but not limited to payment issues) through the Internal Appeals Process and exhaust such appeals process prior to submitting any unresolved disputes through the Forthright alternative resolution (arbitration) process.

Non-treating providers must agree to submit appeals related to non-medical decisions, including but not limited to payment issues through the Internal Appeals Process and exhaust such appeals process prior to submitting any unresolved disputes through the Forthright alternative resolution (arbitration) process. This appeal must be submitted to Prizm within 30 (thirty) days of the issuance of the decision that is the subject of the appeal. Prizm' written response to this appeal will be communicated to the requesting provider by fax or mail within 10 business days of receipt of the request.

Should the assignee choose to retain an attorney to handle the Appeals Process, they do so at their own expense.

- Please note that any provider that has accepted an assignment of benefits must comply with the Appeals Process as noted above prior to initiating arbitration or litigation.

2. Voluntary Network Services

Prizm has established a network of approved vendors for diagnostic imaging studies for all MRI's and Cat Scans, durable medical equipment with a cost or monthly rental over $100.00, prescription drugs and all electrodiagnostic testing, listed in N.J.A.C 11:3-4.5(b) 1-3, (unless performed in conjunction with a needle EMG H-Reflex and NCV studies by your treating provider). If you, the injured party, utilize one of the pre-approved networks, the 30% co-payment will be waived. If any of the electro-diagnostic tests listed in N.J.A.C 11:3-4.5(b) are performed by the treating provider in conjunction with the needle EMG H-Reflex and NCV studies, the 30% co-payment will not apply. The failure to use one of our pre-approved network vendors will result in the imposition of an additional 30% (thirty) co-payment for any services deemed to be medically necessary. If

you, the injured party utilize one of the pre-approved networks, the 30% co-payment will be waived.

When one of the services listed below is authorized through American Commerce Insurance Company's Decision point review/Precertification process, detailed information about voluntary network providers will be made available to the claimant or requesting provider.

Once a diagnostic MRI and/or CAT scan, that is subject to pre-approval through Decision Point Review/ Pre-Certification is authorized, a representative of Prizm will contact the facility and forward the information to them for scheduling purposes. A representative from the diagnostic facility will contact you, the injured party, and schedule the test at a time and place convenient to them.

Durable Medical Equipment with a cost or monthly rental over $100.00 is subject to Decision Point Review/Pre-Certification process and once the Durable Medical Equipment is authorized a representative of Prizm will contact the vendor and forward the information to them for scheduling purposes. The equipment will be shipped to you; the injured party from the vendor, 24 hours after the request is received.

When you are in need of Prescription Drugs, a pharmacy card will be issued that can be presented at numerous participating pharmacies. A list of participating pharmacies will be made available to you once the need for a prescription has been identified.

Once an Electro-diagnostic Test subject to pre-approval through Decision Point Review/ Pre-Certification is authorized a representative of Prizm will contact the vendor and forward the information to them for scheduling purposes. A representative from the diagnostic facility will then contact you, the injured party, and schedule the test at a convenient time and place. When Electrodiagnostic tests are performed by your treating provider, in conjunction with a needle EMG, H-Reflex and NCV studies, the 30% co-payment will not apply.

Co-Payments

If an injured person uses a provider for a MRI, CT Scan or Electrodiagnostic testing from any of the above networks the 30% co-payment as per N.J.A.C 11:3-4.4(f) will not apply. However, if the treating provider performs the needle EMG, H-Reflex and NCV studies himself, this test and associated electrodiagnostics, the injured party would not receive a 30% co-payment.

If the injured party goes outside of the network, the co-payments as stated above will apply.

Payments/ Reimbursement

American Commerce Insurance Company will reimburse all eligible medically necessary services in accordance with the most current New Jersey PIP Regulations and Fee Schedule relating to the date of service.

When provider fees aren't noted in a fee schedule, American Commerce Insurance Company will use the most current version of FAIR Health Data Base, consistent with the date of service, 80th percentile and with the providers' zip code, as proof of a usual, customary and reasonable fee.

For Pharmacy bills which are not noted in a fee schedule, American Commerce Insurance Company will use the most current version of the Goldstandard with the geozip noted on the provider's address noted on this EOB.

American Commerce Insurance Company has no obligation to reimburse for specific CPT/HCPC codes if they were approved (certified) in a Decision Point Review/Precertification request as it relates to applying payment methodology in the NJ PIP regulations, including but not limited to the National Correct Coding Initiative (NCCI) edits. If the NCCI edits prohibit reimbursement for the codes that were billed such codes will not be reimbursed. The New Jersey Department of Banking and Insurance has adopted the NCCI edits to prevent duplication of services and unbundling of codes and the NCCI edits are part of the American Commerce Insurance Company insurer's obligation to only reimburse for medically necessary treatment. To obtain the entire current NCCI edits from the following web site: www.cms.gov/NationalCorrectCodInitEd/

When a provider bills CPT codes for medically necessary services that are not noted in the fee schedule, American Commerce Insurance Company will reimburse the service referencing fees for similar services on the fee schedule or the most current version of FAIR Health Data Base, consistent with the date of service, 80th percentile and with the providers' zip code, as proof of a usual, customary and reasonable fee, whichever is less.