

Personal Injury Protection (PIP) Information for New Jersey

Important Information about our Decision Point Review and Pre-Certification

In accordance with New Jersey law, Amica administers a Decision Point Review (DPR) and Pre-Certification process for specific medical services associated with New Jersey auto insurance claims. The information below applies to New Jersey PIP claims and outlines how required reviews are handled in compliance with applicable state regulations. This summary cannot be construed to replace any provision of your policy. You should read your policy and review your [Declarations page](#) for complete information on the coverages that are provided. If there is any conflict between the policy and this summary, THE PROVISIONS OF THE POLICY SHALL PREVAIL.

After a motor vehicle accident in New Jersey, certain medical care may need to be reviewed before it is provided. New Jersey law requires that certain medical treatments, diagnostic tests and medical equipment related to auto accidents be reviewed to determine whether they are medically necessary and eligible for coverage under Personal Injury Protection (PIP) coverage.

Amica follows New Jersey's PIP requirements (N.J.A.C. 11:3-4.5, 11:3-4.7, and 11:3-4.8) and works with Prizm, an independent medical review organization, to administer Decision Point Review, pre-certification and the internal appeals process.

Prizm, LLC
P.O. Box 5480
Mt. Laurel, NJ 08054

Phone: 856-596-5600

Fax: 856-596-6300

Email: Documents@prizmlc.com

Website: www.prizmlc.com

During the claims process, Prizm may contact the injured person or medical provider to request medical records, clarify a treatment plan or schedule an Independent Medical Examination (IME). These steps help determine medical appropriateness and eligibility for reimbursement. Failure to complete required steps may affect approval or payment of services.

Decision Point Review/Pre-certification process

Your doctor will be asked to submit a comprehensive treatment plan for your injuries. Prizm will review the plan. The plan will be approved if Prizm agrees that the treatment proposed is medically necessary. Your doctor will be notified of the outcome of the review three (3) business days after Prizm's receipt of all necessary information. Treatment may continue while Prizm reviews the treatment plan. However, you and your doctor should be aware that your policy affords coverage only if treatment is determined to be medically necessary.

Providers who submit Decision Point Review/Pre-certification requests are those providers who, in part, physically and personally perform evaluations of the injured person's condition, state the specific treatment and set treatment goals.

Decision Point Review requests will not be accepted from the following providers:



[Get a Quote](#)

[Log In](#)

[800-242-6422](tel:800-242-6422)

- Durable medical equipment companies
- Ambulatory surgery centers
- Registered bio-analytical laboratories
- Licensed health maintenance organizations
- Transportation companies
- Pharmacies

If any of the above restricted providers submits a Decision Point Review/Pre-certification request, Prizm will respond to them no later than three (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.

Step 1: Provider submits a request

The treating health care provider submits a request for pre-certification using the Attending Provider Treatment Plan (APTP) form and supporting medical records.

- Requests must be submitted by a provider who personally examined the patient and is recommending the treatment

Step 2: Request is reviewed

Prizm reviews the treatment plan and medical information on Amica's behalf.

- A decision is usually made within three (3) business days after a complete request is received
- If additional medical information is required, a decision is made within three (3) business days after the additional information is received
- Requests may be denied if the required details are not provided

Step 3: Decision is issued

The provider receives a decision that may:

- Approve the request
- Approve the request with modifications
- Deny the request
- Ask for additional medical information

The provider is responsible for discussing the decision and next steps.

Required forms

New Jersey regulations require the use of specific forms for appeals:

- **Attending Provider Treatment Plan (APTP)** for DPR and pre-certification, including the response being appealed, the appeal rationale and any supporting documentation
- **Uniform Pre-Service Appeal Form** and **Uniform Post-Service Appeal Form** for internal appeals

Forms are also available through the **New Jersey Department of Banking and Insurance** and at www.prizmlc.com

In accordance with the auto insurance claims requirements for the State of New Jersey, documents related to Amica's Decision Point Review Plan can be reviewed below:

Updated documents:

[Decision Point Review Plan Requirements](#)



Get a Quote

Log In

800-242-6422

Where to send documents

Review and appeal requests

All Decision Point Review, pre-certification and internal appeals requests for New Jersey PIP claims must be submitted to Amica's administrator, Prizm:

Prizm, LLC
P.O. Box 5480
Mt. Laurel, NJ 08054

Phone: 856-596-5600
Fax: 856-596-6300
Email: Documents@prizmlc.com
Website: www.prizmlc.com

Medical bills and other claim documents

All other claim related documents and medical bills can be submitted through Amica's standard claims process:

Amica Mutual Insurance
P.O. Box 9690
Providence, RI, 02940

Phone: 800-592-6422
Email: claims@amica.com

Pre-certification does not apply to:

- Emergency care
- Treatment provided within the first ten (10) days following the accident

These services are subject to retrospective review.

Care Paths

Care Paths identify generally accepted treatment guidelines and decision points for specific injuries.

- Providers may request copies of Care Paths from Prizm

Care Paths are available by phone, fax, email or through Prizm's website www.prizmlc.com.

Medical services subject to review

Diagnostic tests requiring Decision Point Review include:

- Magnetic Resonance Imaging (MRI)
- CT/CAT Scans
- Electromyography (EMG), Nerve Conduction Velocity (NCV) and H Reflex studies
- Electroencephalogram (EEG)
- Evoked potential studies
- Dynatron/Cybex studies
- Sonogram/Ultrasound
- Videofluoroscopy
- Brain mapping
- Thermography

Services subject to pre-certification include:

- Non-emergency inpatient and outpatient hospital care
- Non-emergency surgical procedures
- Infusion therapy



[Get a Quote](#)

[Log In](#)

[800-242-6422](tel:800-242-6422)

- 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 Paths
- All physical, occupational, speech, cognitive, rehabilitation or restorative therapy, or therapeutic or body part manipulation, including but not limited to re-evaluations, except that provided for identified injuries in accordance with Decision Point Review
- All outpatient psychological and 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
- Prescription drugs
- Non-emergency medical transport
- Non-emergency dental restorations
- Temporomandibular disorders and oral facial syndrome
- Current perception testing
- Computerized muscle testing
- Nutritional supplements
- All treatment and testing related to balance disorders
- Bone scans
- Podiatry
- Urine drug testing for prescription management or drug abuse identification
- All procedures that use an unspecified CPT/CDT, DSM IV and/or HCPCS code

Decision time frames

Once a complete request is received:

- Decisions may be communicated verbally when appropriate
- Written authorizations, denials, modifications or requests for additional information will be issued within three (3) business days
- If no decision is issued within this time frame, medically necessary treatment may proceed until notification is provided

Independent Medical Examinations (IMEs)

When an IME is required:

- The exam will typically be scheduled within seven (7) calendar days
- The IME will be performed by a provider in the same specialty
- Failure to attend two (2) or more scheduled IMEs without a valid reason may affect payment for future treatment related to the condition

Voluntary networks

Amica offers voluntary provider networks through Prizm for certain services, including:

- MRI scans
- Electrodiagnostic tests (EEGs, NCVs, EMGs)
- Durable medical equipment (such as wheelchairs and hospital beds)
- Prescription drugs

With the exception of prescription drugs, the patient will be responsible for a 30% co-payment if the above services or items are obtained outside of Prizm's network. The patient must first pay the deductible plus any applicable co-payment amounts and will then be responsible for 30% of the remaining costs for products and services. For prescription drugs obtained outside of Prizm's network, a \$10 co-payment will apply per fill and refill.

For additional network information, providers may contact Prizm:

Phone: 856-596-5600

Fax: 856-596-6300

Email: Documents@prizmlc.com

Website: www.prizmlc.com

Penalty co-payments

If the accident is not reported to us within thirty (30) days, we may reduce any payment you receive for covered injuries as follows:

- A 25% reduction if we are notified thirty (30) or more days after the accident; or
- A 50% reduction if we are notified sixty (60) or more days after the accident.

Any reduction will affect reimbursement for covered medical expenses you incur beginning thirty (30) days after the accident and until we are notified of the accident. The reduction will be applied:

- After any medical expense, benefits deductible or co-payments; and
- After any other co-payments imposed under our Decision Point Review / Pre-certification Plan.

Denials and internal appeals

If Prizm's Physician Advisor has determined that treatment is not medically necessary, coverage for the treatment will be denied. This written decision will be faxed followed by mail. Prizm's Physician Advisor will be available to discuss the decision with your doctor. Prizm will grant a request for reconsideration of its decision when additional information can be provided to Prizm for a second review. If reconsideration cannot resolve the difference of opinion, the matter may be appealed.

Pre-service appeals

Your doctor must request an internal appeal, regarding a decision related to a treatment request prior to the performance or issuance of the requested service. This request must be submitted within thirty (30) days of Prizm's decision denying coverage. This appeal must contain a properly completed Pre-Service Appeal Form, the original Attending Provider Treatment Plan being appealed, the Decision Response document being appealed, an appeal rationale narrative and the appeal physician's signature and the reason(s) for reconsideration along with any additional supporting documentation. If the required information is not submitted at the time the pre-service appeal is received, the appeal will be denied. The provider will be notified of the inefficiencies contained in the appeal submission and will be given the opportunity to resubmit correctly.

If it is determined that an Independent Medical Examination is necessary, the appointment shall be scheduled within seven (7) days of the appeal request unless the injured person agrees to extend the time period.

Prizm's written response to the appeal will be communicated to the provider within fourteen (14) days after receipt of the appeal request.

Post-service appeals

If the appeal is for any issue other than treatment denials or modifications made through a Physician Advisor Review or an Independent Medical Examination (IME), and is submitted

days of receipt of the explanation of benefits and at least forty-five (45) days prior to initiating alternate dispute resolution under N.J.A.C. 11:3-5.

The request must include a properly completed Post-Service Appeal Form, the original bill, the explanation of benefit/payment, the signature of the treating provider, and the reason(s) for reconsideration, along with any additional supporting documentation.

If the required information is not submitted at the time the post-service appeal is received, the appeal will be denied. The provider will be notified of any deficiencies in the appeal submission and will be given the opportunity to resubmit with the correct information.

Further dispute resolution options

If a provider disagrees with the outcome of an internal appeal, additional dispute resolution options may be available under New Jersey law. After completion of the internal appeal process, a provider may pursue dispute resolution through the New Jersey Personal Injury Protection dispute resolution process administered by the state's designated Dispute Resolution Organization. Information regarding the dispute resolution process, including how to file a request, is available through the designated Dispute Resolution Organization (currently **Forthright**) or the **New Jersey Department of Banking and Insurance**.

Internal appeals must be completed before arbitration or litigation is initiated.

Appeal requests and required documents should be sent to Prizm:

Fax: 856-596-6300

Email: Documents@prizmlc.com

Mail: Prizm, LLC, P.O. Box 986, Marlton, NJ 08053

Assignment of benefits

Providers accepting an assignment of benefits must comply with the applicable Decision Point Review and internal appeals requirements and complete required appeals before pursuing other dispute resolution options.

Failure to complete these steps may result in benefits no longer being payable to the provider.

Important notice

This information is provided for general guidance and does not alter, amend or replace the terms of any insurance policy. Coverage determinations are based on New Jersey law, applicable regulations and policy language.

[Account](#) [Billing](#) [Policies](#) [Claims](#) [Profile](#)

Products

[Auto](#) [Home](#) [Life](#) [Condo](#) [Renters](#) [Flood](#) [Annuities](#) [Marine](#) [Motorcycle](#) [Umbrella](#) [Small Business](#) [All Products](#)

About Us

[About Us Overview](#)
[Annual Report](#)
[Careers](#)
[Charitable Grants](#)
[Company Facts and History](#)
[Diversity, Equity and Inclusion](#)
[Licensing Information](#)
[Media Center](#)
[Our Commitment to Ethics](#)

Tools & Services

[Amica Mobile App](#)
[Car Connection](#)
[Contractor Connection](#)
[Roadside Assistance](#)



[Get a Quote](#)

[Log In](#)

[800-242-6422](#)