



## HANOVER DECISION POINT REVIEW/PRE-CERTIFICATION PLAN BROCHURE

### Introduction

We strive to process claims for medically necessary medical treatment and testing in a quick and fair manner.

Under the terms of the Hanover Insurance policy, when an accident causing injury occurs, the insured is required to notify Hanover Insurance and provide information regarding the facts of the accident, the nature and cause of the injury, the diagnosis and anticipated course of treatment. This information is required to be provided promptly after the accident and periodically thereafter.

**Please read this brochure** carefully as it explains how your medical claim will be processed, including Decision Point Review and Pre-certification requirements which you and your medical provider must follow. If you have any questions, please call your Claim Representative at 1-800-628-0250.

### DECISION POINT REVIEW AND PRE-CERTIFICATION REQUIREMENTS

**Under the provisions of your policy and New Jersey regulations, Decision Point Reviews and/or Pre-certification of specified medical treatment and testing is required, for medically necessary expenses to be fully reimbursable under the policy.** The information in this brochure will provide an overview of Pre-certification and Decision Point requirements. Please read your policy, policy terms and conditions for the actual Pre-certification and Decision Point requirements.

#### **What is a Decision Point Review?**

The New Jersey Department of Banking and Insurance has published standard courses of treatment for soft tissue injuries of the neck and back. These are called Care Paths and provide your medical provider with general guidelines for treatment and diagnostic testing. The Care Paths include requirements that your medical provider consult with us at certain stages in your treatment. These are called Decision Point Reviews.

In addition, the administration of any test listed in N.J.A.C. 11:3-4.5(b)1-10 also requires Decision Point Review, regardless of the diagnosis. The *Care Paths* and accompanying rules are available on the internet at the Department's website at [www.nj.gov/dobi/aicrapg.htm](http://www.nj.gov/dobi/aicrapg.htm), by contacting Allmerica Utilization Review at 1-800-853-7540 or through our website ([www.allmerica.com](http://www.allmerica.com)).

#### **What is Pre-certification?**

Pre-certification is required for injuries not included in the Care Paths described above. Pre-certification means that a medical professional will review the treatment plan submitted by your medical provider to make sure that you are receiving the appropriate level of medical care for your injuries. This does not mean that you need to obtain our approval before consulting your medical provider when you are injured. Your medical provider, however, is required to submit a treatment plan and/or request approval for specified treatment and diagnostic testing outlined in your policy.

Services that require pre-certification are listed on Exhibit B.

#### **What do I need to do to comply with the Decision Point Review and Pre-certification requirements in my policy?**

Give us the name, address and phone number of your medical providers. We will then contact them by

phone and in writing to explain the entire process. You should also give your medical provider a copy of the Injury Notification Information on the back of your insurance card.

**How do I know what type of treatment needs a Decision Point Review or Pre-certification?**

When we contact your medical provider, we will furnish complete information regarding the type of treatment or services requiring Decision Point Review or Pre-certification. If you would like more information, please contact your Allmerica Utilization Review Representative at 1-800-853-7540.

Treatment in the first 10 days after an accident and emergency care do not require Decision Point Review or Pre-certification. However, for benefits to be paid in full, all treatment must be medically necessary.

**How does the Decision Point Review/Pre-certification process work?**

Your medical provider is responsible to supply treatment/Decision Point information and request pre-certification of treatment and diagnostic testing in accordance with the requirements of your policy. We will encourage your medical provider to provide a detailed treatment plan, whenever possible, so that your treatment will not be interrupted.

In order for Hanover to complete the review, your health care provider is required to submit all requests on the "Attending Provider Treatment Plan" form. A copy of this form can be found at the Department's website at [www.nj.gov/dobi/aicrapg.htm](http://www.nj.gov/dobi/aicrapg.htm), by contacting Allmerica Utilization Review at 1-800-853-7540 or through our website ([www.allmerica.com](http://www.allmerica.com)).

When we receive a Decision Point Review or Pre-certification request from your medical provider, along with the appropriate medical documentation, your provider will be notified within three business days whether or not our medical professional agrees with the treatment plan submitted. If your medical provider is not notified within three business days, they may continue your test or course of treatment until a final determination is communicated to him. Any decision to deny a decision point review or pre-certification request based on medical necessity will be the determination of a physician or dentist.

If we do not agree, you have the right to appeal our decision using Allmerica Medical/Utilization Management Program appeal process. If we do not agree with the treatment plan, you still have the right to continue treatment, but the expenses will not be reimbursable under your policy if the treatment is determined not to be medically necessary.

If we do not agree with your medical provider's treatment plan, we may also request that you attend an Independent Medical Examination.

If an Independent Medical Examination is requested, treatment may proceed while the exam is being scheduled and until the results are available.

**How does my Medical Provider request a Decision Point Review or Pre-certification?**

Requests for Decision Point Reviews and Pre-certification of medical treatment should be directed to:

Allmerica Utilization Review  
440 Lincoln Street  
Worcester, MA 01653  
Phone #: 800-853-7540  
Fax #: 508-854-1730

**What happens if my medical provider does not request a Decision Point Review or Pre-certification of medical treatment, as required in my policy?**

If your medical provider does not submit requests for decision point review or pre-certification as required by your policy, or your medical provider does not submit clinically supported findings that support the request, your expenses for medically necessary treatment, testing and durable medical equipment will be subject to an additional co-payment of 50%. Treatment which is not medically necessary is not reimbursable.

**Can my medical provider appeal the Decision Point Review or Pre-certification decision?**

Yes. If Hanover fails to certify a request, the clinical rationale for this determination is available to you and/or your health care provider upon written request. If your health care provider would like to have the decision reconsidered, they can participate in Hanover's internal appeal process by notifying Hanover of their intention to participate in the appeal process by phone, fax or in writing to:

Allmerica Utilization Review  
440 Lincoln Street  
Worcester, MA 01653  
Phone #: 800-853-7540  
Fax #: 508-854-1730

If your provider has taken an assignment of benefits, he will be required to participate in this process. The reconsideration process will occur within three (3) business days of the receipt of the request and all supporting documentation for an Expedited Appeal, and within 14 days of the receipt of the request and all supporting documentation for a Standard Appeal.

If you have any questions regarding medical services which have been denied or certified, you can contact the Allmerica Utilization Review customer services line at 1-800-853-7540. You can also contact your Hanover Claim Representative at 1-800-628-0250.

**What are the requirements and consequences if I am requested to attend an Independent Medical Examination?**

If the need arises for you to attend an Independent Medical Exam during the decision point review/pre-certification process, you and your treating provider will receive prior notification. The exam will be:

- Scheduled within seven (7) days of receipt of the request unless you agree with us to extend the time period;
- Conducted by a provider in the same discipline as your treating provider;
- And conducted at a location reasonably convenient to you.

You may be requested to provide medical records and other pertinent information to the examining physician at or before the examination. The failure to provide requested medical records or other pertinent information at or before the exam will be considered an unexcused failure to attend the exam and the exam will not take place. You will be notified of the decision within three (3) business days after attendance at the exam. If the examining provider prepares a written report concerning the examination, you or your treating provider will be provided with a copy upon request. Treatment may proceed while the examination is being scheduled and until the results become available.

If you have two (2) or more unexcused failures to attend the scheduled exam, notification will be immediately sent to you, and all health care providers treating you for the diagnosis (and related diagnosis) contained in the attending physicians treatment plan form. The notification will place you on notice that all future treatment, diagnostic testing or durable medical equipment required for the diagnosis (and related

diagnosis) contained in the attending provider treatment plan form will not be reimbursable as a consequence for failure to comply with the plan.

## **Voluntary Networks**

### **Does the plan provide voluntary networks for certain services, tests or equipment?**

We do not provide a network of primary health care providers. Your primary medical provider is selected by you. Your policy does, however, encourage you to obtain certain services and/or supplies from networks of pre-approved vendors. The networks currently available include Prescription Drugs, Durable Medical Equipment with a cost or monthly rental greater than \$100, Diagnostic Imaging (MRI and CAT scans), and the Electro-diagnostic tests listed in N.J.A.C. 11:3-4.5(b)1 through 3, except when performed by the treating physician. If you obtain medically necessary services and/or supplies from a pre-approved vendor from one of these networks, you will be fully reimbursed for those services and/or supplies consistent with the terms of your policy and the N.J. Medical fee Schedule. If you choose to use a vendor that is not part of these pre-approved networks, a 30% co-payment (\$10 for prescription drugs) will apply to the eligible charges. For additional information, contact Allmerica Utilization Review at 1-800-853-7540 or your claim representative at 1-800-628-0250.

## **DEDUCTIBLES AND CO-PAYMENTS**

### **What is my deductible?**

**Unless otherwise indicated** on the declarations page of the policy, medical expense benefits are subject to a \$250 deductible per accident.

### **What is my co-payment?**

All other Medical Services - 20% per accident up to \$5,000

### **Are there any other co-payments?**

If the Decision Point Review or Pre-certification **requirements** in your policy are **not met**, including failure to submit requests for decision point review or pre-certification or failure to provide clinically supported findings that support the request, your expenses for medically necessary treatment and testing will be subject to an **additional** co-payment of 50%. Treatment, which is not medically necessary, is **not** reimbursable.

If you do not promptly inform us about the facts of the accident, the nature and cause of injury, the diagnosis, and anticipated course of treatment, an additional co-payment penalty may apply as follows:

- A co-payment of 25% if the information is received 30 or more days after the accident; or
- A co-payment of 50% if the information is received 60 or more days after the accident.

## **ASSIGNMENT OF BENEFITS**

### **Can I assign my benefits?**

Yes, but only to a provider of service benefits. Please read the Assignment of PIP Benefits section in your policy carefully. All assignments are subject to all requirements, duties and conditions of the policy, including but not limited to Pre-certification, Decision Point Reviews, exclusions, deductibles, co-payments and duties of cooperation. In addition, if your provider takes an assignment of benefits, your provider is required to hold you harmless for any penalty imposed by us for your provider's failure to adhere to the requirements of our Decision Point Review Plan.

## ALLMERICA UTILIZATION REVIEW

### EXHIBIT A

#### Identified Injuries

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

## ALLMERICA UTILIZATION REVIEW

### EXHIBIT B

#### Diagnostic Tests that are subject to Decision Point Review:

1. Brain audio evoked potentials (BAEP);
2. Brain evoked potentials (BEP);
3. Computer assisted tomograms (CT, CAT scan);
4. Dynatron/cybex station/cybex studies;
5. Electroencephalogram (EEG);
6. H-reflex studies;
7. Magnetic resonance imaging (MRI);
8. Needle electromyography (EMG);
9. Nerve conduction velocity (NCV);
10. Somatosensory evoked potential (SSEP);
11. Sonogram/ultrasound;
12. Videofluoroscopy;
13. Visual evoked potential (VEP);
14. Bone scans;
15. Myelograms;
16. Brain mapping;
17. Thermography.

Any other diagnostic test that is subject to the requirements of our Decision Point Review Plan by New Jersey law or regulation.

#### The following services require pre-certification:

1.	Non-emergency in-patient and out-patient hospital care (including the appropriateness and duration of the hospital stay);
2.	Non-emergency surgery (performed in a hospital, freestanding surgical center, office, etc.);
3.	Durable medical equipment (including orthotics and prosthetics) with a cost or monthly rental in excess of \$100;
4.	Extended care and rehabilitation;
5.	Home health care;
6.	Infusion therapy;
7.	Outpatient psychological/psychiatric testing and/or services;
8.	All physical, occupational, cognitive, speech or other restorative therapy, or body part manipulation except that provided for Identified Injuries in accordance with Decision Point Review; and,
9.	All pain management services except that provided for Identified Injuries in accordance with Decision Point Review;
10.	Non-emergency dental restoration;
11.	Non-emergency dental services including temporomandibular disorders or any oral facial syndrome.

## Allmerica Utilization Review – Voluntary Networks

Allmerica Utilization Review has contracted with voluntary networks for the provision of the following services:

1. Prescription Drugs and Durable Medical Equipment with a cost or monthly rental in excess of \$100 are provided by **Progressive Medical**. Progressive Medical is part of an approved workers compensation managed care organization.
2. **MedFocus** provides diagnostic imaging (MRI's and CAT scans) and the electro-diagnostic tests included in N.J.A.C. 11:3-4.5b. 1-3, except when performed by the treating physician. MedFocus is part of an approved workers compensation managed care organization.

The above networks provide services at convenient locations throughout the state. When an insured voluntarily obtains any of the above listed services from a network provider, the 30% co-payment (\$10 for prescription drugs) will be waived.

The claimant and provider are notified of the voluntary networks immediately following report of the accident to Hanover. The information is contained in the Dear Doctor Letter and insured's Brochure, with a telephone number for the provider or insured to access additional information regarding network providers.

## **DECISION POINT REVIEW PLAN NARRATIVE**

### **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*. (For a list of Identified Injuries by ICD-9 codes, see Exhibit A.) N.J.A.C. 11:3-4 also establishes guidelines for the use of certain diagnostic tests. The *Care Paths* provide the treatment to be evaluated at certain intervals called *Decision Points*. On the *Care Paths*, Decision Points are represented by hexagonal boxes. At decision points you must provide us information about further treatment you intend to provide (*Decision Point Review*). In addition, the administration of any test on the list in Exhibit B also requires *Decision Point Review* regardless of the diagnosis. The *Care Paths* and accompanying rules are available through Allmerica Utilization Review at 1-800-853-7540 or on the New Jersey Department of Banking and Insurance website at <http://www.nj.gov/dobi/aicrapg.com>. If an insured fails to request decision point review where required, or fails to submit clinically supported findings that support the request, payment of the insured's bills may be subject to a penalty co-payment of 50% even if the services are determined to be medically necessary.

Once an insured is involved in a motor vehicle accident (MVA), we are informed that he/she will begin treatment, pursuant to N.J.A.C. 11:3-4, the treating doctor is required to provide us with notification for certain tests or services that he may order. This notification is provided in connection with Decision Point Review and Pre-certification. The Hanover Insurance Companies and The Hanover New Jersey Insurance Company has contracted Allmerica Utilization Review to be the review organization involved with the Decision Point Review and Pre-certification process.

Please note that Decision Point Review and Pre-certification requirements begin after the 10<sup>th</sup> day following a motor vehicle accident and do not apply to Emergency Care. However, this provision does not require reimbursement of tests and treatment that are not medically necessary regardless of when they occur.

### **MANDATORY PRE-CERTIFICATION**

If the patient does not have an Identified Injury, the treating doctor is required to obtain pre-certification for all services itemized in Exhibit B. If the doctor fails to request pre-certification where required or fails to submit clinically supported findings that support the request, payment of the bills may be subject to a penalty co-payment of 50% even if the services are determined to be medically necessary. The doctor is encouraged to maintain communication with Allmerica Utilization Review on a regular basis as Decision Point Review requirements may change.

### **VOLUNTARY PRE-CERTIFICATION**

The doctor is encouraged to participate in a *Voluntary Pre-certification* process by providing Allmerica Utilization Review with a comprehensive treatment plan for both identified and other injuries. Allmerica will utilize nationally accepted criteria and the *Care Paths* to work with the doctor to certify a mutually agreeable course of treatment to include itemized services and a defined treatment period. In consideration for the doctor's participation in the Voluntary Pre-certification process, the bills submitted, when consistent with pre-certified 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 treatment plan means that as long as treatment is consistent with the plan, additional notification to Allmerica Utilization Review at decision points and for services requiring pre-certification will not be required.

### **HOW TO SUBMIT DECISION POINT REVIEW AND PRECERTIFICATION NOTIFICATIONS**

In order to complete our review, we require that the treating doctor provide us with any past medical history that is available. We also require the diagnosis, prognosis, all x-ray and other test results that may have been completed, and documentation of all treatment provided to date. We ask that the doctor indicate any tests or treatment anticipated over the next 30 days.

All Decision Point Review and Pre-certification requests will be submitted using the enclosed Attending Provider Treatment Plan form. The form is available by calling Allmerica Utilization Review at 1-800-853-7540, through our website ([www.allmerica.com](http://www.allmerica.com)) or at [www.nj.gov/dobi/aicrapg.htm](http://www.nj.gov/dobi/aicrapg.htm).

The completed form, along with a copy of the most recent/appropriate progress notes and the results of any tests relative to the requested services to must be submitted to:

Allmerica Utilization Review  
440 Lincoln St.  
Mail Stop S306  
Worcester, MA 01653.

The doctor may also contact Allmerica Utilization Review at 1-800-853-7540 with the request.

Our review of decision point review and pre-certification notifications will be completed within three (3) business days of receipt of the necessary information. Notice of certification will be made to the doctor's office by telephone and confirmed in writing. If we fail to notify the doctor within three (3) business days, the doctor may continue with the test or treatment until a final determination is communicated to him/her. In addition, if an independent physical or mental examination is required, treatment may proceed while the exam is being scheduled and the results become available. Any decision to deny a decision point review or pre-certification request based on medical necessity will be the determination of a physician or dentist.

## **REVIEW OUTCOMES**

The following are a list of the possible outcomes as a result of a Decision Point Review or Pre-certification request:

- Requested service is certified.
- In the event we receive insufficient information that does not support the requested service, a pending status letter/administrative denial will be issued and will continue until we receive documentation sufficient to evaluate the request for the diagnostic test or service.
- In the event that we must amend the requested services (either frequency, duration, intensity or place of service or treatment), the doctor's office will be notified by telephone and confirmed in writing and an Allmerica physician advisor or other medical professional will be available to discuss the case with the doctor.
- In the event we are unable to certify the request, the doctor's office will be notified by telephone and confirmed in writing. An Allmerica physician advisor or other medical professional will be available to discuss the case with the doctor. If the request is for a surgical procedure, the claims adjuster will assist the patient/insured to schedule a second surgical opinion, at the expense of Hanover Insurance.
- Pursuant to N.J.A.C. 11:3-4 and the patient's/insured's policy: Failure to request decision point review or pre-certification where required or failure to submit clinically supported findings that support the request can result in a 50% penalty co-payment for treatment or tests that are determined to be medically necessary.
- In the event the notice and supporting materials are insufficient to authorize or deny reimbursement for further services, we may require that the patient/insured undergo an Independent Medical Examination.

## **INDEPENDENT MEDICAL EXAMINATION**

If we request the patient/insured to undergo an Independent Medical Examination (IME) during the decision point review/pre-certification process, the doctor will be notified of the date, time, and location of the exam. The IME will be scheduled within 7 days of our receipt of the Attending Provider Treatment Plan form (unless the patient/insured agrees to extend the time period) with a provider in the same discipline and at a location reasonably convenient to the patient/insured. At our request, the patient/insured may be required to provide medical records, x-rays, and other pertinent information at or before the time of the IME. The doctor will be notified of the results of the IME within 3 business days after attendance of the IME. If the examining provider prepares a written report, a copy of the report will be made available upon request.

## **IME PROVISIONS**

If the patient/insured has more than one unexcused failure to attend the scheduled IME, notification will immediately be sent to the patient/insured, attorney if noted, and all providers treating for the diagnosis (and related diagnosis) contained in the Attending Provider Treatment Plan form. The notification will place the patient/insured on notice that all future treatment, diagnostic testing, or durable medical equipment required for the diagnosis (and related diagnosis) contained in the Attending Provider Treatment Plan form will not be reimbursable as a consequence for failure to comply with the plan.

Failure of the patient/insured to provide requested medical records, x-rays, or other pertinent information at or before the IME will be considered an unexcused failure to attend the IME.

## **ADDITIONAL PENALTY CO-PAYMENT**

N.J.A.C. 11:3-4.4(e) provides for the production of information from the insured regarding the facts of the accident, the nature and cause of the injury, the diagnosis and anticipated course of treatment. This information may be required promptly after the accident and periodically thereafter. An additional co-payment penalty of 25% may apply if information is received 30 or more days after the accident or 50% when the information is received 60 or more days after the accident.

## **RECONSIDERATION PROCESS**

When Allmerica fails to certify a request, clinical rationale for this determination is available upon request. If treating doctor would like to have the decision reconsidered, the doctor will utilize Allmerica's internal appeal process by contacting Allmerica at 1-800-853-7540.

## **VOLUNTARY NETWORK SERVICES**

The patient's policy includes a voluntary Utilization Program for Prescription Drugs, Durable Medical Equipment over \$100, Diagnostic Imaging and Electro-diagnostic Testing. The network for diagnostic imaging applies to MRI's and CAT scans. The network for electro-diagnostic tests applies to the electro-diagnostic tests listed in N.J.A.C. 11:3-4.5(b) 1 through 3, except when performed by the treating physician. A 30% co-payment (\$10 for prescription drugs) is applicable to these services. The services are paid in full when an eligible injured person voluntarily uses a provider from the network.

## **NON-NETWORK SERVICES**

Non-network services may be used. However, they are still subject to the decision point review/pre-certification process and are subject to a 30% co-payment penalty.

## **ASSIGNMENT OF BENEFITS**

These benefits shall not be assignable except to providers of services. Any such assignment is not enforceable unless treating doctor agrees to be subject to the requirements of our Decision Point Review Plan, including Pre-certification; utilize Allmerica's internal Appeal Process for reconsideration of denials of certification, and submit disputes not resolved through the internal Appeal Process to alternate dispute resolution pursuant to N.J.A.C. 11:3-5. In addition, the treating doctor must agree to hold an "insured" or "eligible person" harmless for any penalty imposed by us for the treating doctors failure to adhere to the requirements of our Decision Point Review Plan, including Pre-certification.

The staff at Allmerica remains available to answer questions and assist with the Decision Point Review and Pre-certification process and can be reached at 1-800-853-7540.

## **TRANSITION PLAN**

Hanover New Jersey Insurance Company and Hanover Insurance Company will implement the revised Decision Point Review Plan as follows:

- For claims open prior to the effective date of the revised plan, the treating provider is faxed the determination for his latest decision point review and/or pre-certification request, as well as the transition notice, copy of the revised plan requirements and copy of Attending Provider Treatment Plan form.
- The treating provider is advised that the requirements of the revised plan will apply to the next Decision point Review or Pre-Certification request.
- A copy of the new plan requirements will be sent to the claimant as well. By this process, all open claims will be transitioned to the revised plan within 90 days of the effective date of this filing.

**ALLMERICA UTILIZATION REVIEW MANAGEMENT PROGRAM**  
**NEW JERSEY APPEAL PROCESS FOR UTILIZATION REVIEW**

A. EXPEDITED APPEAL PROCEDURE

If after a determination of non-certification has been made and either the attending physician, facility, covered person or patient believes said decision should be immediately reviewed, the expedited appeal procedure should be followed. Under this process, upon being notified of the request for immediate review, the Utilization Review Analyst immediately makes arrangements with a Physician Reviewer in a relevant specialty which typically manages the proposed treatment plan, other than the Physician Reviewer who made the previous determination of non-certification, to contact the attending physician regarding the non-certification.

Upon notification of the request for an expedited appeal, all measures will be taken to have the discussion between the physicians take place on the day of the requested appeal. A determination will be communicated to the requester within 3 business days following receipt of the expedited appeal request. After review of the information provided by the attending physician, if again the services are not certified, the standard appeal process should be followed.

B. STANDARD APPEAL PROCEDURE

Within 60 days from the date of the non-certification determination, either the attending physician, facility, covered person or patient should indicate their desire to appeal said decision in writing or by phone directed to the Allmerica Utilization Review management program. The grounds for appeal as well as any and all supporting documentation should be provided.

The Allmerica Utilization Review management program may request and require copies of medical record(s) or further written documentation from the facility and/or physician. Any and all such documentation and the appeal will then be reviewed with a Physician Reviewer in a relevant specialty which typically manages the proposed treatment plan, other than the Physician Reviewer who made the previous determination of non-certification. After the Allmerica Utilization Review management program receives the appeal and any and all clinical information, said appeal will be reviewed and a determination will be made within 14 days. Based upon this review, if a reversal of the original determination is indicated, the attending physician, facility, covered person and patient involved will be so notified by the Allmerica Utilization Review management program.

If the original non-certification determination is not changed, the physician, facility, covered person and patient will so be notified. Upon request, the clinical information as to the determination will be provided within the above-noted time frames.

All final determinations will be provided to the claims payor. All information as well as documentation will be kept in the strictest of confidence.

If we cannot reach an agreement under the expedited or standard appeal procedure, a resolution can still be pursued within the Alternate Dispute Resolution Forum, as provided in accordance with N.J.A.C. 11:3-5.

If you have any questions regarding medical services which have been denied, you can contact Allmerica Utilization Review at 1-800-853-7540, ext. 5925. You can also contact your Hanover Claim Representative at 1-800-888-4925 or 1-800-257-5720.