The American Commerce Insurance Company's insurance policy outlines comprehensive procedures and requirements for treatment related to soft tissue injuries of the neck and back, termed Identified Injuries. Treatment is assessed at specific intervals known as Decision Points, where the Named Insured, Eligible Injured Person, or treating healthcare provider must submit information regarding further treatment. Emergency care and treatments within the first ten days post-accident are exempt from the Decision Point Review, although only medically necessary treatments will be reimbursed. To initiate a Decision Point Review or precertification, the treating provider must submit a completed attending provider treatment form along with clinically supported findings via fax or online, with the review conducted within three business days. If additional documentation is required, a physical examination may be scheduled, and failure to attend may affect future reimbursements. Precertification is mandatory for services not related to Identified Injuries and must be requested by the Named Insured or their healthcare provider, with penalties, including a 50% co-payment, imposed for incorrect submissions. The company may also require periodic updates on the injury and claim, with penalties for late submissions.

Voluntary precertification is encouraged for healthcare providers, allowing for a comprehensive treatment plan that simplifies the reimbursement process if approved. The policy features a Preferred Provider Organization (PPO) network, which is voluntary, allowing the insured to choose their healthcare provider. Precertification requirements apply after ten days post-accident, with a claims representative contacting the insured to confirm coverage and explain the precertification process. A Nurse Case Manager is assigned to assist throughout treatment, providing a toll-free number for inquiries. All medical bills are processed through the AIS office, where they are reviewed for medical necessity and matched against treatment authorizations. Discrepancies may lead to further review. The Assignment of Benefits clause restricts assignment rights to licensed healthcare providers who comply with specific conditions, including adherence to the Decision Point Review Plan and the internal appeals process. The policy includes a three-level review process for treatment requests, starting with the Nurse Case Manager, followed by a Physician Advisor review,

and a third-level appeal by board-certified healthcare providers. Appeals must be initiated within fourteen days of a denial, with specific documentation required.

The policy also details the appeal process for adverse decisions regarding medical claims under Personal Injury Protection (PIP) coverage, allowing providers fourteen calendar days from notification of an adverse decision to file an appeal in writing to the Nurse Case Manager. The appeal process includes a Healthcare Provider Clinical Review, which will be conducted within fourteen calendar days or an expedited appeal within three business days, depending on medical need. Certain services not included in the Care Paths require precertification, including non-emergency inpatient and outpatient care, surgical procedures, extended rehabilitation, outpatient therapies, psychological services, and durable medical equipment costing over $50. Requests for decision point reviews and precertification must include clinically supported findings; non-compliance results in a penalty co-payment of 50% on bills, even if deemed medically necessary. The insurer will notify the provider of the reimbursement decision within three business days.

Providers are encouraged to participate in a voluntary precertification process, which allows for streamlined payment of services consistent with the approved treatment plan. The policy establishes networks of pre-approved vendors for diagnostic tests and durable medical equipment, ensuring full reimbursement for services obtained from these vendors, while non-network services will be reimbursed at a reduced rate. Insured individuals must promptly notify the company about their injury and claim, providing necessary details about the accident, injury, diagnosis, and treatment plan. Failure to provide this information may result in additional co-payments, specifically 25% if submitted 30 days post-accident and 50% if submitted 60 days post-accident. The policy includes an Internal Appeals Process for disputing decisions regarding medical necessity or bill payments, requiring appeals to be submitted within 14 calendar days of a denial. The Nurse Case Manager will determine the appeal process, which can be expedited if necessary, and unresolved issues may be

escalated to an Alternate Dispute Resolution Organization. The policy prohibits the assignment of benefits to healthcare providers unless they comply with specific conditions, including adherence to the Decision Point Review Plan and the internal appeals process, with non-compliance nullifying any assignment of benefits. The insurer may also require an independent medical examination (IME) to assess the necessity of further treatment, with appointments scheduled within seven days unless extended by the injured party. Treatment may continue while awaiting IME results, but only medically necessary treatment related to the accident will be reimbursed. Overall, adherence to the outlined procedures is crucial for maintaining coverage and reimbursement eligibility.