ORDER NO. A12-118

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

IN THE MATTER OF THE REQUEST OF THE)
NEW JERSEY ASSOCIATION FOR JUSTICE FOR)
A STAY OF THE ADOPTION OF AMENDMENTS)
AND NEW RULES, N.J.A.C. 11:3-4.2, ET SEQ)

This matter arises out of a request by the New Jersey Association for Justice, (hereafter referred to as "NJAJ"), dated December 10, 2012, for a stay of the adoption of new rules, amendments and repeals concerning Personal Injury Protection ("PIP") Benefits, PIP Dispute Resolution, and the PIP Fee Schedules for Physicians, Ambulatory Surgical Centers ("ASCs"), Hospital Outpatient Surgical Facilities ("HOSFs"), Dentists, Durable Medical Equipment, and Ambulance Services as adopted at 44 N.J.R. 2652(c) on November 5, 2012 (hereinafter generally as "the rules"), pending the NJAJ's appeal of the adoption of the rules to the Appellate Division of the Superior Court.

The Notice of Adoption of the rules was published in the New Jersey Register on November 5, 2012. With the exception of certain amendments – including the "on-the-papers" arbitration process raised by NJAJ herein - that will not become operative until November 5, 2013, the rules and fee schedules will become operative on January 4, 2013. Prior to publishing the Notice of Proposal of the rules, the Department engaged in a lengthy advance notice of rulemaking process pursuant to Executive Order 2 which included the exchange of information and comments with interested parties, including medical providers and insurers. The proposal was published in the New Jersey Register at 43 N.J.R. 1640(a) on August 1, 2011, and more than 18,000 written comments were received. Subsequently, on February 21, 2012, a Notice of Proposed Substantial Changes Upon Adoption was published in the New Jersey Register at 44

N.J.R. 383(a) pursuant to N.J.S.A. 52:14B-4.10, and more than 100 comments were received on that Notice.

In support of its motion, NJAJ states that the rules are unlawful and invalid as a matter of law in that they exceed the Department's statutory authority because: (1) the Department has not demonstrated that the PIP rules need to be amended; (2) the rules add a new "on-the-papers" process for PIP arbitrations that violates due process and equal protection; (3) the rules contravene the PIP statute and existing case law with respect to the assignment of benefits by insureds to providers; (4) the rules impermissibly alter the criteria for the award of attorneys' fees in PIP arbitration proceedings; (5) the definition of "standard professional treatment protocols" in the rules contravenes the PIP statute, the New Jersey Rules of Evidence and legal precedent; (6) the rules err by requiring payments in PIP arbitrations to be made to the appealing provider who was assigned the insured's PIP benefits; and (7) the new internal appeals process in the rules conflicts with the applicable statute of limitations, provides too short a time period, and improperly imposes penalties upon providers and attorneys.[1] NJAJ asserts that, based upon these purported defects, they have a strong probability of success on their challenge to the legality of the rules. NJAJ also contends that a stay pending appeal will benefit the public interest, favor the balance of equities and prevent the risk of irreparable harm that would result from implementation of the rules.

STANDARD OF REVIEW

It is well settled that NJAJ has the burden of establishing that a stay should be granted in this matter by clear and convincing evidence. American Employers' Insurance Co. v. Elf

[1] As noted above, the Department implemented a delayed operative date for the internal appeals process because it had determined that issues raised by commenters demonstrated further review and amendment of the procedure is necessary. Therefore, these rules will not become operative for one year to allow the Department sufficient time to conduct further dialogue with interested parties and revamp the process through a new rulemaking. For these reasons, the Department will not address the merits of NJAJ's arguments regarding the internal appeals process.

Atochem N.A., Inc., 280 N.J. Super. 601, 611, fn8 (App. Div. 1995); Subcarrier Communications, Inc. v. Day, 299 N.J. Super. 634, 639 (App. Div. 1999) (citing American Employers' Ins. Co., supra). In this application, NJAJ has failed to carry this burden to demonstrate clear and convincing evidence for the requested relief.

A stay pending appeal of a final administrative decision, including the adoption of administrative rules, is an extraordinary equitable remedy involving the most sensitive exercise of judicial discretion. See Crowe v. DeGioia, 90 N.J. 126, 132 (1982); Zoning Board of Adjustment of Sparta v. Service Electric Cable Television of N.J., Inc., 198 N.J. Super. 370, 379 (App. Div. 1985). It is not a matter of right, even though irreparable injury may otherwise result. Yakus v. United States, 321 U.S. 414, 440, 64 S. Ct. 660, 674, 88 L. Ed. 834 (1944). Because it is the exception rather than the rule, GTE Corp. v. Williams, 731 F.2d 676, 678 (10th Cir. 1984), the party seeking such relief must clearly carry the burden of persuasion as to all the prerequisites. United States v. Lambert, 695 F.2d 536, 539 (11th Cir. 1983). Granting a stay pending appeal is the exercise of an extremely far-reaching power, one not to be indulged in except in a case clearly warranting it.

Such relief is appropriate only in instances where the party seeking this extraordinary measure demonstrates that each of the following conditions has been satisfied: (1) a reasonable probability of success on the merits of the underlying appeal; (2) the public interest favors such relief; (3) on balance, the benefit of the relief to the movant will outweigh the harm such relief will cause other interested parties, including the general public; and (4) irreparable injury will result if a stay is denied. Crowe v. DeGioia, 90 N.J. 126, 132-134 (1982). NJAJ's request for a stay fails to meet their burden of demonstrating facts that satisfy any of the required four Crowe elements.

LIKELIHOOD OF SUCCESS ON THE MERITS

First, NJAJ failed to establish that there is a reasonable probability that it will prevail on the merits of its appeal. It is "well-established" that administrative regulations enjoy a presumption of validity. N.J. State League of Municipalities v. Department of Community Affairs, 158 N.J. 211, 222 (1999). As held in the last PIP rule appeal, it is well-settled in this State that a party challenging a regulation's validity has the burden of overcoming that presumption and demonstrating that the regulation is arbitrary, capricious, or unreasonable. Bergen Pines County Hosp. v. N.J. Dep't of Human Servs., 96 N.J. 456, 477 (1984); In re Adoption of N.J.A.C. 11:3-29, 410 N.J. Super. 6, 22-24 (App. Div.), certif. denied 200 N.J. 506 (2009). "A finding that an agency acted in an ultra vires fashion in adopting regulations is generally disfavored. Particularly, in the field of insurance, the expertise and judgment of the [agency head] may be given great weight." N.J. Coalition of Health Care Professionals, Inc., v. N.J. Dep't of Banking and Ins., Div. of Ins., 323 N.J. Super. 207, 229 (App. Div.), certif. denied, 162 N.J. 485 (1999) (citations omitted). In the context of actions by an administrative agency, "arbitrary and capricious" means "willful and unreasoning action, without consideration and in disregard of circumstances." Bayshore Sewerage Co. v. Department of Envtl. Protection, 122 N.J. Super. 184, 199 (Ch. Div. 1973), aff'd, 131 N.J. Super. 37 (App. Div. 1974), quoted in Worthington v. Fauver, 88 N.J. 183, 204-05 (1982). Action that is "exercised honestly and upon due consideration," is not arbitrary and capricious, even if there is room for another option and "even though it may be believed that an erroneous conclusion has been reached." Bayshore Sewerage Co., supra, 122 N.J. Super. at 199. As discussed in full below, NJAJ has failed to demonstrate any likelihood that they would be able to sustain this burden and prevail in their appeal of the rule adoption.

A) Justification for the PIP Rule Adoption

NJAJ asserts that the Department has to demonstrate that there is a need and/or crisis to justify the PIP rule adoption, and that without doing so the rules are not likely to withstand the appellate challenge. Additionally, NJAJ attacks the Department's statistics regarding PIP losses, makes general unsupported assertions that the new rules will decrease the value of the PIP benefit to injured persons, and asserts that the rules will make it more difficult for PIP patients to obtain quality healthcare and for providers to obtain proper payment for services rendered. All of these assertions are incorrect and fail to demonstrate a reasonable probability of success on the merits.

First, NJAJ is incorrect that the Department has to demonstrate a need and/or crisis to justify amendment of the PIP rules and fee schedules. N.J.S.A. 39:6A-4.6 requires the Commissioner to adopt fee schedules that incorporate the reasonable and prevailing fees of 75 percent of practitioners on a regional basis for the purpose of establishing reimbursement rates for medical procedures and other related services covered under the PIP benefit coverage provided by private passenger automobile ("PPA") insurance. Additionally, that statute also requires biennial adjustments for inflation and for the addition of new medical procedures. In total, the statutory scheme governing PPA insurance and PIP benefits has been repeatedly reformed by the Legislature to cut and contain auto insurance rates for consumers and I have been granted broad statutory authority to achieve this goal. In light of this, the Department does not need a specific justification or crisis to update the PIP rules and fee schedules.

Nevertheless, the Department provided multiple reasons for the new amendments during the rulemaking. First, the update to the existing fees on the Physicians' Fee Schedule was necessary because the 2007 PIP Adoption was based upon data from 2005-06, but the fees did

not go into effect until 2009 due to the litigation challenging the adoption. Also, the update of the entire fee schedule, and not just an inflation adjustment, was necessary to incorporate changes in the 2011 Medicare Resource Based Relative Value System ("RBRVS") that changed the appropriate fees for certain procedures due to changes in their work and practice expenses and to reflect new rates of utilization for expensive equipment. Furthermore, the Department determined it was necessary to add approximately 1,100 new CPT codes to the schedule due to increased billings of infrequently performed procedures, and the need for enhanced cost certainty for PIP benefits. These reasons have been fully explained and supported by the Department in the rulemaking, and provide sufficient justification for this rulemaking to sustain an appellate challenge.

Additionally, the PIP loss experience data and the recent requests for PPA rate increases by carriers demonstrate that PIP expenses continue to exert an upward pressure on auto insurance rates. Contrary to NJAJ's assertions, the auto insurance cost containment goals repeatedly espoused by the Legislature are a continuing statutory obligation of the Department, and therefore continued monitoring and review is not only appropriate, but required to ensure a robust market for all New Jersey PPA insurance consumers. In this adoption, the Department is making statutorily required cost of living changes to the medical fee schedules, incorporating changes in medical terminology and practice, closing loopholes exploited by some providers that are depriving insureds of the full benefit of their claim dollar, and fulfilling the cost containment mandate of N.J.S.A. 17:33B-42, which exists irrespective of loss ratios or profitability. Furthermore, the adopted rules do not decrease the value of the PIP benefit to the insured by making it more difficult for insureds to obtain care as asserted by the NJAJ. On the contrary, the rules increase the value of the PIP benefit by addressing overutilization, the exploitation of

loopholes and fraud by unscrupulous providers, all of which deprive insureds of the full benefit of their claim dollar.

Lastly, as discussed during the rulemaking in response to NJAJ's comments, the Department did not rely on stale PIP loss data when the rule was proposed. At that time, 2009 data was all that was available. Although loss ratios for PIP have decreased over the last 10 years, this decrease in PIP loss ratios is not because of a significant decrease in the frequency or severity of PIP claims, it is because PIP premiums have increased. A loss ratio is calculated by dividing premiums by losses and expenses. The ratio can be lowered by a decrease in losses or an increase in premium and the data shows that neither the frequency or severity of PIP losses has decreased significantly. This unfavorable PIP experience of insurers has justified rate increases that have gradually reduced those loss ratios. This is the "upward pressure on rates" referred to by the Department that further supports this rulemaking.

For these reasons, NJAJ has not demonstrated that it is likely to prevail on the merits of its challenge to the justification for this PIP rule adoption.

B) PIP Dispute Resolution Proceedings "On-the-Papers" & Payments of PIP Arbitration Awards

NJAJ also asserts that the new rule permitting "on-the-papers" consideration of limited PIP alternate dispute resolution proceedings violates traditional notions of due process and equal protection.[2] This assertion is incorrect and fails to demonstrate a reasonable probability of success on the merits of the appeal.

N.J.S.A. 39:6A-5.1 does not require in-person hearings, but instead provides for dispute resolution of PIP disputes, often known as PIP arbitrations, and it gives the Commissioner the exclusive power to promulgate rules as to the conduct of the PIP dispute resolution proceedings.

[2] NJAJ makes no specific arguments regarding equal protection and therefore this Order will not further examine this issue.

The Department and NJAJ agree that due process is a flexible concept and at a minimum requires an opportunity to be heard at a meaningful time and in a meaningful manner. Doe v. Poritz, 142 N.J. 1, 106 (1995). However, NJAJ contends that the only way to satisfy due process is to permit in-person proceedings in all PIP arbitrations. There is nothing in the text of N.J.S.A. 39:6A-5.1 that requires an in-person hearing or the taking of testimony in PIP arbitrations, and the Legislature expressly delegated the determination of the appropriate conduct of PIP arbitrations to the Commissioner for enactment as an administrative rule. Plus, the Department understands from the current PIP arbitration vendor – Forthright – that the vast majority of PIP arbitration proceedings are conducted now without any oral testimony from the parties.

In further refutation of NJAJ's contention that the only way to satisfy due process is for an in-person proceeding, the Department notes that other statutory arbitration schemes contain "on-the-papers" proceedings and permit summary disposition (i.e. FINRA's arbitration procedure is available for claims up to $50,000, and other statutory arbitration schemes (N.J.S.A. 2A:23B-15) permit summary disposition on the papers without limiting such to where no facts are in dispute). The Department does not believe that requiring "on-the-papers" arbitrations for reimbursement claims less than $1,000 violates due process or is in any way unfair. Forthright's rules as approved by the Department merely provide for "on-the-papers" proceedings where no future treatment is at issue and the claim is less than $1,000.[3]

The "on-the-papers" process provides sufficient due process because it gives the parties an opportunity to be heard at a meaningful time and in a meaningful manner. Specifically, the parties will be provided notice, have an opportunity to submit initial papers including evidential

[3] Furthermore, the rules provide if coverage under the policy is at issue, fraud is suspected, or causation is an issue, then the insurer can remove the matter for an in-person hearing. Thus, the only cases where the "on-the-papers" hearings will be mandatory are reimbursement disputes between the insurer and providers for medical services already provided where the claim is for less than $1,000.

exhibits and certifications, and will have an opportunity to submit reply submissions responding to each other's initial submissions. This process affords the parties adequate opportunities to submit the appropriate evidence to support their positions and is sufficient to satisfy due process concerns. Furthermore, billing disputes as to the usual, customary and reasonable provider fees of less than $1,000, although at times contentious, often turn on two considerations: 1) whether the billed fee is the providers' usual and customary fee; and 2) whether the fee sought by the provider is reasonable given the fees paid by the insurer to geographically similar providers, that provider, and as indicated in databases of fees. These determinations for nominal reimbursement disputes are appropriate for analysis and determination on the papers because the key evidence concerns the providers' prior bills and the insurers' evidence of payments and database information. For all these reasons, NJAJ has failed to demonstrate that the "on-the-papers" process violates due process, or a reasonable probability of prevailing on this issue on appeal.

NJAJ also asserts that this $1,000 limit was arbitrarily selected by the Department. This is incorrect. As explained in the adoption, the Department selected the $1,000 threshold for "on-the-papers" cases because it was recommended by Forthright as the level that would comprise approximately 25 percent of filed arbitrations and amounts less than that are considered relatively nominal reimbursement disputes. The Department also stated that it will monitor the implementation of the "on-the-papers" provision and may revise the threshold in the future based on actual experience. This determination by the Department is well within its expertise and statutory authority to establish the conduct of PIP arbitrations, and similarly fails to demonstrate a likelihood of prevailing on appeal.

NJAJ also contends that the Department's amendments to N.J.A.C. 11:3-5.6(f) requiring that payment of the award go to the appealing provider with the assignment of benefits changes

past practices of either paying the full award to the arbitration attorney and permitting the attorney to distribute the provider's reimbursement, or having the insurer issue two checks. NJAJ cites no statutory authority for this objection, and appears to be asserting that the rule change is unreasonable because it changes past practices. The Department notes that most regulatory amendments change past practices, and this in and of itself is insufficient to demonstrate the rule is unreasonable. The Department believes this requirement is appropriate given that the scope of the assignment of benefits only extends to the provider, and as an administrative cost cutting measure for insurers that issued two checks – one to the provider and one to the attorney. In total, NJAJ has presented insufficient evidence to demonstrate that this policy determination is arbitrary, capricious or unreasonable.

In light of the above, NJAJ has not demonstrated a reasonable probability of success on the merits of these issues on appeal.

C) Assignments of Benefits and Duties

NJAJ asserts that the Department has erred by requiring the assignment of duties and benefits in N.J.A.C. 11:3-4.9. First, NJAJ misreads the amendment to N.J.A.C. 11:3-4.9 which is permissive and only provides that an "insured may only assign benefits and duties under the policy to a provider of service benefits." (Emphasis supplied). NJAJ also asserts that this amendment contravenes the Appellate Division's decision in Selective Ins. Co. of America v. Hudson East Pain Management Osteopathic Medicine and Physical Therapy, 416 N.J. Super. 418 (2010), aff'd on other grounds 210 N.J. 597 (2012). NJAJ fails to note that the Supreme Court did not adopt the reasoning of the Appellate Division in this matter, and fails to recognize that neither decision precluded the assignment of duties under the policy to a provider of service benefits. As noted by the Supreme Court on certification, the Appellate Division relied upon the

legally significant distinction between an assignment, which conveys benefits or the potential to receive benefits, and a delegation, which conveys duties or obligations. Selective, supra, 416 N.J. Super. at 426 (citing 9 Corbin on Contracts §§ 47.1, 47.6 (John E. Murray, Jr. ed. 2007)). Based upon this distinction, the Appellate Division held that a general assignment of benefits in the PIP context and the specific assignment at issue in the matter at bar did not function to impose the duty to cooperate under the policy unless the assignee providers expressly assent to assume the duty or were a party to the original agreement. Ibid.

In July 2012, the Supreme Court issued its decision in the case, in which it declined to express its views on this issue. In so doing, the Court pointed to the Restatement (Second) of Contracts (1979), which recognized that "[t]he principle that an assignment of benefits does not carry with it the corresponding duties of the assignor is not universal in its application[,]" and noted that the Legislature has incorporated such assumptions of duties in other statutory assignments of benefits (see N.J.S.A. 12A:2-210(4)). Selective Insurance v Hudson East, supra, 210 N.J. at 606-607. The Supreme Court ultimately held that the duties of the assignee can be no greater than those of the assignor, and because the insured under the policy could not be compelled to provide the type of information sought by the insurer, then neither could the provider under the "duty to cooperate" clause. Id. at 607. Furthermore, the Court held that in PIP arbitrations, N.J.S.A. 39:6A-13(g) limits the exchange of discovery to information concerning a patient's "history, condition, treatment, dates and cost of such treatment" and the scope of this cannot be expanded. Id. at 608. The Department's rule does not seek to subvert or extend either decision.

The purpose of the amendment to N.J.A.C. 11:3-4.9 is to clarify the issue of whether duties under an auto insurance policy are assignable to providers generally, and to permit an

insurer to require that a provider accept the duty to cooperate if assigned by the insured. In the adoption, it was noted that certain providers have refused to respond to reasonable information requests by insurers in connection with the investigations of claims and that this clarification regarding the permissible assignment of both benefits and duties will enable insurers to require the provision of information during those investigations as long as legally permissible. As noted in the adoption, many carries already include a requirement that providers submit to examinations under oath ("EUOs") in their restrictions on the assignment of PIP benefits, and EUOs are one of the most common duties of an insured in an investigation of a claim. Therefore, requiring providers to submit to EUOs in the investigation of a PIP claim does not extend their duties past those of the insured in violation of the Selective decision. Moreover, nothing in the rule expands the scope of discovery in PIP arbitrations beyond the statutory limits of N.J.S.A. 39:6A-13(g). In fact, the Department by adopting this provision seeks to prevent a significant number of arbitrations by enabling insurers to get the information needed to investigate and pay claims. Furthermore, the Department intends to monitor its implementation and the specific duties sought for assignment to providers in PPA insurers' policy forms. The Department believes that this rule is necessary to eliminate confusion and is well-within its statutory authority to "implement any procedure or practice ... to prevent fraudulent practices by the insured, insurers, providers of services or equipment . . ." under N.J.S.A. 17:33B-42. In light of the above, NJAJ has failed to demonstrate a likelihood of prevailing on the merits of this issue on appeal.

D) Attorney's Fees in PIP Arbitrations

In further support of the contention that it is likely to prevail on the merits of its appeal, NJAJ asserts that the Department erred by adding a process to N.J.A.C. 11:3-5.6 by which

dispute resolution professionals ("DRPs") shall award reasonable attorney's fees to successful claimants. Specifically, NJAJ argues that the adopted new rules violate the New Jersey Constitution and exceed the Department's statutory authority because they attempt to regulate the practice of law, which is the exclusive province of the New Jersey Supreme Court. NJAJ also argues that the Department erred by not including a process for contingency fee enhancements in the rules. NJAJ's arguments do not to demonstrate that they are likely to prevail on the merits of the appeal on this issue.

The adopted rule requiring DRPs to analyze requests for attorney's fees in PIP arbitrations does not unconstitutionally invade the Supreme Court's exclusive regulation of the practice of law. In N.J.S.A. 39:6A-5.1, the Legislature established the PIP arbitration process which specifically provided that the "[C]ommissioner shall promulgate rules and regulations with respect to the conduct of the dispute resolution proceedings." Moreover, N.J.S.A. 39:6A-5.2(g) specifically provides that, "[t]he cost of the proceedings shall be apportioned by the dispute resolution professional. Fees will be determined to be reasonable if they are consonant with the amount of the award, in accordance with a schedule established by the New Jersey Supreme Court." As noted during the rulemaking, the Supreme Court has not established a schedule according to this statute. However, the Supreme Court and the appellate jurisprudence of this State have established a clear process for determining the reasonableness of attorney's fee awards under fee-shifting statutes such as N.J.S.A. 39:6A-5.2(g). Under the Legislature's mandate to adopt rules governing the conduct of the PIP arbitrations, the Department has merely incorporated the courts' own jurisprudence into N.J.A.C. 11:3-5.6(e), which requires DRPs to analyze the reasonableness of attorney's fee awards. The adopted amendments require the DRP to complete and memorialize the courts' attorney fee analysis in the arbitration decision prior to

making an award of attorney's fees. Thus, this rulemaking is well within the Department's purview to regulate the conduct of the PIP arbitrations.

As put forth during the rulemaking, the Department obtained data on the amounts awarded to claimants and paid to attorneys in 2010. It appeared from this data that in many instances DRPs failed to complete the statutorily required analysis to determine if the requested fee amounts are consonant with the amount of the award pursuant to N.J.S.A. 39:6A-5.2(g), and made no analysis of the reasonableness of the attorney fee request under the jurisprudence of this State. Of the 10,703 awards that included attorney's fees, in 3,460, or 31 percent of them, the attorney fee awarded was higher than the PIP benefits awarded. For example, one attorney received a fee of $3,380 for a case where only $375 was awarded in PIP benefits. The most common attorney fee awarded for all cases was $1,200. For cases where the PIP benefit awarded was $500 or less, the most common attorney fee was $1,000. For cases where the PIP benefit awarded was between $5,000 and $10,000, the most common attorney fee was $1,200. NJAJ asserts that the Department has failed to put forth evidence that attorney's fees "are too high in PIP cases." However, as noted above and in the adoption, this has never been the Department's assertion. The Department's assertion is that N.J.S.A. 39:6A-5.2(g) requires the attorney's fees to be consonant with the amount of the award, and the data received by the Department showed that this analysis was not taking place. In fact, in its submission before the Commissioner, NJAJ agrees that "DRP's are not awarding fees that are 'consonant' with the amount of the award," and it attempts to say that there are valid reasons for this awarding of fees in violation of N.J.S.A. 39:6A-5.2(g). However, there is no valid reason to violate the statutory requirement of consonance. NJAJ's own admission demonstrates the need for the Department's rule requiring DRPs to complete the statutorily required consonance analysis and the reasonableness analysis

required by the case law of this State. Overall, the Department's incorporation of this case law into the rules to require DRPs to determine the reasonableness of the requested attorney's fees is not arbitrary, capricious or unreasonable.

As noted above, the Department incorporated the jurisprudence of this State that establishes how to determine the reasonableness of attorney fee awards under a fee-shifting statute such as N.J.S.A. 39:6A-5.2(g), which specifically provides that the fees should be consonant with the amount of the arbitration award. See, Rendine v. Pantzer, 141 N.J. 292, 335-345 (1995); Szczepanski v. Newcomb Medical Center, Inc., 141 N.J. 346 (1995); Furst v. Einstein Moomjy, Inc., et al., 182 N.J. 1 (2004); Allstate Ins. Co. v. Sabato, 380 N.J. Super. 463, 472-474 (App. Div. 2005); and Scullion v. State Farm Ins. Co., 345 N.J. Super. 431 (App. Div. 2001). NJAJ asserts that the Department misconstrued this jurisprudence by failing to include upward adjustments of attorney's fees in cases where the attorney's compensation is not guaranteed. I disagree that this argument demonstrates that NJAJ is likely to prevail on the merits of the appeal.

The adopted rule incorporates the basic lodestar analysis in the case law that comports with the statutory authority in N.J.S.A. 39:6A-5.2(g) requiring the attorney's fee to be "consonant" with the amount of the PIP arbitration award. The Department believes that contingency fee enhancements in most instances would run counter to this statutory requirement, and therefore the adopted rule does not specifically provide for a contingency fee enhancement analysis as authorized in Rendine, supra, 141 N.J. at 337-341. Additionally, as noted by the Rendine court, any contingency enhancement should consider whether the "likelihood of success is unusually strong" and evaluate whether the risk that counsel would come away empty-handed is remote. Id. at 340-341. To what degree attorneys in PIP arbitrations operate on a contingency

fee basis is not known to the Department; moreover, PIP arbitrations are not as procedurally complex or time consuming as traditional litigation, where attorneys who agree to a contingency fee agreement incur substantial expenditures of time, resources, and risk of non-payment. Nevertheless, nothing in the rule prohibits counsel from requesting such contingency fee enhancements in PIP arbitration awards and, if requested, DRPs would have to analyze whether an upward adjustment of the lodestar is appropriate and "consistent with the jurisprudence of this State," as espoused in Rendine. See N.J.A.C. 11:3-5.6(e).

NJAJ also incorrectly asserts that the Department's rule improperly equates "consonant" with "proportionate." In N.J.A.C. 11:3-5.6(e)2, the Department directs the DRPs to analyze whether the attorney's fee is "consonant with the amount of the award" when the amount of the arbitration award is less than the attorney fee award under N.J.S.A. 39:6A-5.2(g). To do so, DRPs must focus on whether the fees in those circumstances are compatible or consistent with the amount of the award in accordance with the definition of "consonant" previously noted by this court in Coalition I, supra, 323 N.J. Super. at 261-62. Additionally, N.J.A.C. 11:3-5.6(e)2 directs the DRPs to make a heightened review of the "lodestar" calculation where a request for attorney's fees is grossly disproportionate to the amount of the award. Szczepanski, supra, 141 N.J. at 366-67; Scullion, supra, 345 N.J. Super. at 437-38. The Department does not confuse "consonance" with "proportionality" in the rules because the rules provide for two separate analyses by the DRP - one to evaluate the consonance of the attorney's fee when compared to the award as required by N.J.S.A. 39:6A-5.2(g) and the other to conduct a heightened review of the lodestar if the attorney fee award is grossly disproportionate to the amount of the PIP award.

In light of the above, NJAJ has failed to demonstrate a reasonable probability of success on the merits of this issue on appeal.

E) Standard Professional Treatment Protocols

NJAJ asserts that the new definition of "standard professional treatment protocols" in N.J.A.C. 11:3-4.2, which requires evidence-based clinical guidelines/practice/treatment published in peer-reviewed journals as a method of determining disputed medical necessity, violates the "No-Fault" Act, the New Jersey Rules of Evidence and applicable case law.[4] For the following reasons, NJAJ fails to demonstrate a reasonable probability of success on the merits of this issue on appeal.

First, the Department's new definition comports with its statutory authority under N.J.S.A. 39:6A-4(a). The definition of "medical necessity" in N.J.S.A. 39:6A-4(a) reads in part,

> Medical treatments, diagnostic tests, and services provided by the policy shall be rendered in accordance with commonly accepted protocols and professional standards and practices which are commonly accepted as being beneficial for the treatment of the covered injury. Protocols and professional standards and practices and lists of valid diagnostic tests which are deemed to be commonly accepted pursuant to this section shall be those recognized by national standard setting organization, national or state professional organizations of the same discipline as the treating provider, or those designated or approved by the [C]ommissioner in consultation with the professional licensing boards . . .

Based upon this statute, the Department implemented a regulatory definition of "medically necessary or medical necessity," which has been in N.J.A.C. 11:3-4.2 for many years, and this definition contains the phrase, "standard professional treatment protocols." The Department is simply defining that term. Furthermore, the definition of "standard professional treatment

[4] NJAJ makes no attempt to explain how the New Jersey Rules of Evidence's standard for submission of scientific evidence in a court has any bearing on determinations of medical necessity in the treatment of PIP patients, the Legislature's definition of same in N.J.S.A. 39:6A-4(a), and the Department's rules interpreting this definition under an express grant of statutory authority. Consequently, this assertion will not be further discussed.

protocols" is not inconsistent with the definition of "medical necessity" in N.J.S.A. 39:6A-4(a), and is not, as NJAJ also contends, inconsistent with unspecified case law.

This detailed definition of medical necessity in N.J.S.A. 39:6A-4(a) was added by the Automobile Insurance Cost Reduction Act ("AICRA") in 1998 after the decision in Thermographic Diagnostics, Inc. v. Allstate Ins. Co., 125 N.J. 491, (1991), defined medical necessity. "[T]he Legislature is presumed to be aware of judicial construction of its enactments," and the Thermographic Diagnostics methodology of determining medical necessity was under a prior version of N.J.S.A. 39:6A-4, which did not contain the above language, and it is therefore no longer applicable. DiProspero v. Penn, 183 N.J. 477, 494 (2005) (citations omitted). However, even the court in Thermographic Diagnostics recognized that, "[t]he use of the treatment, procedure, or service must be warranted by the circumstances and its medical value must be verified by credible and reliable evidence." Thermographic Diagnostics, supra, 125 N.J. at 512.

The Legislature's subsequent AICRA amendment provides a basic methodology on how to determine that the medical value of the treatment is verified by credible and reliable evidence by defining what constitutes standard professional treatment protocols under PIP. This post-Thermographic Diagnostics amendment to the statute specifically provides for the Commissioner to make policy determinations as to what treatment is reasonable, appropriate and necessary, and the new definition of standard professional treatment protocols in this adoption is well within the this statutory authority. For these reasons, the Department does not believe that the medical necessity standard set forth in Thermographic Diagnostics has any relevance to the adopted rule amendment, and NJAJ has failed to demonstrate a likelihood that they will prevail on this issue on appeal.

For all the reasons above, it is clear that NJAJ has failed to demonstrate a reasonable probability of success on the merits of the appeal, and therefore it is not entitled to a stay of the rules pending appeal. However, in order to provide a complete analysis, the following will address the other three criteria set forth in Crowe.

PUBLIC INTEREST

The public interest does not favor a stay of these rules pending appeal. NJAJ asserts that the public interest will benefit from a stay of the PIP adoption because the rules will interfere with the ability of medical providers to properly treat their patients and obtain proper compensation for their services, and therefore the rules will have a negative impact on all persons injured in auto accidents. NJAJ does not explain in any detail or provide any support as to how the new PIP rules and fee schedules will have this impact. As demonstrated below, the interests of the public are best served through implementation of the new PIP rules and fee schedules.

PIP patients will continue to receive the same standard of care and providers will provide the same standard of care under the new rules and fee schedules. Permitting the new and amended rules to become effective on January 4, 2013, will benefit the interests of New Jersey auto insurance consumers, PIP patients and providers. In enacting N.J.S.A. 39:6A-4.6(a), the Legislature required the Commissioner to develop fee schedules that reflect the prevailing fees for services in connection with PIP coverage. In Coalition for Quality Health Care, 358 N.J. Super. 123 (App. Div. 2003), the Appellate Division directed the Department to consider promulgating a more comprehensive Physicians' Fee Schedule than that in the former rules. The court did so because the inclusion of more CPT codes in the PIP fee schedules will enable insurers and providers to streamline their respective claims payment and submission systems,

thereby reducing the administrative component of their total costs and fostering a reduction in the cost of PIP coverage. For this reason, and because these rules implement the public policy of this State expressed by the Legislature and interpreted by the courts as set forth above, the adoption of the new and amended rules is plainly in the public interest.

As noted in the Proposal, the new Physicians' Fee Schedule also increases the fees received for the CPT codes currently on the fee schedule by an average of 7 percent. These increases will enable providers to obtain higher reimbursements for medical procedures, dental treatments, ambulance services and durable medical equipment, all of which were delayed by the stay of the 2007 adoption. Moreover, the rules will benefit auto consumers and providers by setting new fee schedule amounts for more than 1,100 new CPT codes using the updated Medicare RBRVS schedule and at fee amounts based upon paid fees from FAIR Health at the 75th percentile, the NY Worker's Compensation Fee Schedule, and the auto insurer paid fee data. This will provide cost certainty and billing simplification for an expanded number of medical treatments, decrease the need for arbitrations arising from disputes as to procedures' usual, customary and reasonable fee, and further the cost containment goals of AICRA by exerting downward pressure on rising PIP premiums. Additionally, the new rules and schedules will ensure that only medical procedures that can be safely performed in ASCs will be reimbursable under PIP coverages, and expand the cost certainty encouraged by AICRA to HOSFs providing outpatient surgical procedures.

For all of these reasons and contrary to NJAJ's assertions, the public interest favors permitting the new and amended PIP rules and fees schedules to take effect.

BENEFITS VS. HARM OF GRANTING THE APPLICATION

On balance, the benefit of granting the stay will not outweigh the harm such relief will cause other interested parties. NJAJ has provided no facts on which it may be concluded that the balance of the equities favors them. In contrast, permitting the implementation of these new and amended rules and fee schedules will benefit the vast majority of providers and New Jersey auto insurance policyholders, and this must be considered when balancing the equities. The rules effectuate substantial increases in the fees for most of the codes listed in the current Physicians', dental, and durable medical equipment fee schedules. Further delaying the date on which these changes will become operative will adversely affect providers who perform the procedures and render the services to which these codes correspond.

In addition, the challenged adoption is the culmination of the Department's most recent efforts to fulfill the statutory mandate to establish a comprehensive fee schedule and update that fee schedules for inflation every two years. The rules implement the beneficial public policies that the application of current and comprehensive PIP fee schedules were intended to serve, including the dampening effect such schedules have on the administrative costs of providing PIP coverage and medical care to auto accident victims. The adopted amendments also add a significant number of codes to the fee schedules. The adoption of this more comprehensive Physicians' Fee Schedule and of the amendments that address the fees that may be charged by ASCs will reduce the upward pressure on rates currently caused by the frequency of disputes and expensive arbitrations. And, in sum, these amendments will foster a maximization of PIP benefits for all auto insureds. Thus, the balance of equities does not support granting the requested relief.

IRREPARABLE HARM

Irreparable harm will not result to NJAJ or PIP patients and providers if the stay is denied. NJAJ asserts that the procedural changes to the PIP system will have to be reversed if the rules are set aside in the appeal. The procedural changes complained of by NJAJ are largely monetary reimbursements that would be due attorneys and providers, and therefore they do not constitute irreparable harm. Bd. of Ed. of Union Beach v. N.J. Ed. Ass'n, et al, 96 N.J. Super. 371, 391 (Ch. Div. 1967), aff'd 53 N.J. 29 (1968).

Furthermore, NJAJ states that the "less obvious harm" is the risk that providers will stop treating PIP patients due to the regulatory changes. This assertion is mere speculation by NJAJ. In fact, this hypothetical effect of the PIP adoption is belied by the facts which demonstrate that these rules and fee schedules will benefit both providers and PIP insureds. The physician reimbursements are going up an average of 7 percent across-the-board under the new schedule, and 85 percent of the fees are higher than the FAIR Health paid fee data at the 75th percentile. By primarily basing the levels of fees in the revised Physicians' Fee Schedule upon paid fee data supplied by FAIR Health at the 75th percentile and data reflecting claim payments actually made by auto insurers, and by utilizing the methodology affirmed by the Appellate Division in In re Adoption, supra, the Department has ensured that the payment levels in the new schedule are not inappropriately low, but instead meet the statutory standard of approximating the reasonable and prevailing fees at the 75th percentile on a regional basis. Additionally, NJAJ has supplied no facts in support of its assertion of a possible access to care crisis for PIP patients, and it has merely listed a speculative parade of horribles that will result from the rules becoming operative. Indeed, during each adoption of PIP rule amendments, one or more parties have made this argument; however, each PIP adoption and the new fee schedules associated therewith have

eventually become operative with little to no revision after appellate review, and yet, no treatment crisis has ever occurred.

Finally, as I stated in Order No. A12-114, it is incumbent upon me to note that truly irreparable harm could result from a stay of these rules. These rules provide necessary, but reasonable, reimbursement increases for all PIP providers of medical and dental treatments, transportation, therapy, and DMEs, which were delayed by the litigation of the 2007 PIP amendments and the lengthy stay of implementation of those rules for almost two years. They also strike an appropriate balance by including more than 1,100 new CPT codes in the schedule to ensure cost certainty which will result in fewer arbitrations over UCR, a reduction in fraudulent activity, and the containment of PIP premium costs for all New Jersey auto insureds. A lengthy delay of the implementation of these rules will be costly across the board, and in particular to New Jersey policyholders and providers. This is an added consideration as to why this stay request must be denied.

Based upon the foregoing, NJAJ has failed to carry its burden and establish that irreparable harm will befall any parties should the rules go into effect on January 4, 2013.

CONCLUSION

In sum, NJAJ has failed to demonstrate by clear and convincing evidence any of the four prerequisites it was their burden to establish in order for a stay to be granted. Consequently, for all the foregoing reasons, the application for a stay must be, and is hereby, DENIED.

IT IS SO ORDERED this 21st day of December, 2012.

Kenneth E. Kobylowski
Acting Commissioner