

INSURANCE  
DEPARTMENT OF BANKING AND INSURANCE  
DIVISION OF PROPERTY AND CASUALTY

Medical Fee Schedules: Automobile Insurance Personal Injury Protection and Motor Bus Medical Expense Insurance Coverage

Adopted Repeals and New Rules: N.J.A.C. 11:3-29 Appendix, Exhibits 1, 4, 5 and 6

Adopted New Rule: N.J.A.C. 11:3-29 Appendix, Exhibit 7

Adopted Amendments: N.J.A.C. 11:3-29.1, 29.2, 29.3, and 29.4,

Proposed: September 5, 2006 at 38 N.J.R. 3437(a)

Adopted: August 29, 2007 by Steven M. Goldman, Commissioner, Department of Banking and Insurance.

Filed: August 31, 2007 as R. 2007 d. 305 with substantive and technical changes not requiring additional notice or public comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 17:1-8.1, 17:1-15e and 39:6A-4.6.

Effective Date: October 1, 2007.

Expiration Date: June 7, 2011.

**Summary** of Public Comments and Agency Responses:

The Department of Banking and Insurance (Department) timely received 305 written comments from the following:

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Roy D. Vingan, MD	North Jersey Brain & Spine Center
Viswanathan Rajaraman, MD	North Jersey Brain & Spine Center
Daniel Walzman, MD	North Jersey Brain & Spine Center
Douglas Bradley, MD	The Back Institute
Paul Ratzker, MD	Neurological Associates of N. Jersey
Marvin Friedlander, MD	Neurological Associates of N. Jersey
James M. Chimenti, MD	Neurological Associates of Central Jersey
Robert F. Heavy, MD	Neurological Institute of New Jersey

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 Dr. Mincey  
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 Edward von der Schmidt, III, MD  
 Norman M. Heyman, M.D.  
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 William L. Klempner, M.D.  
 Marvin P. Rosenberg, M.D.  
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 David H. Livigston, M.D.  
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 Richard M. Hodosh, MD  
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Integrated Healthcare

Robert Wood Johnson Medical School  
 Robert Wood Johnson Medical School  
 Robert Wood Johnson Medical School  
 Robert Wood Johnson Medical School

Neurological Associates of Central Jersey

Neurological Associates of New Jersey  
 Neurological Associates of New Jersey  
 Neurological Associates of New Jersey

Institute For Spine and Scoliosis

Coastal Spine  
 Coastal Spine  
 Coastal Spine  
 Coastal Spine  
 Robert Wood Johnson Medical School  
 American College of Surgeons

Spine Institute of Southern New Jersey  
 Neurological Care of New Jersey  
 North Jersey Neurosurgical Associates  
 North Jersey Neurosurgical Associates

Bergen-Passaic Neurosurgical Associates  
 UMDNJ Hospital – University Hospital

Metropolitan Neurosurgery Associates  
 Metropolitan Neurosurgery Associates  
 Metropolitan Neurosurgery Associates  
 Metropolitan Neurosurgery Associates  
 Electrodiagnostic Medical Society of NJ  
 Atlantic Brain & Spine Institute  
 Union County Neurosurgical Associates  
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Thomas R. Peterson, MC  
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Gynecologic Cancer & Pelvic Surgery, LLC

Atlantic Healthcare

Jersey Shore Medical Center  
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Medical Society of NJ

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Ponzio Medical Associates  
 New Jersey Spine Group

West End Physical Therapy

Midlantic Medical Review, Inc.

New Jersey Knee & Should Center  
 New Jersey Knee & Shoulder Center  
 Shore Orthopaedic University Associates  
 Shore Orthopaedic University Associates  
 Shore Orthopaedic University Associates  
 The Pain Relief Center  
 Association of NJ Chiropractors  
 Associates in Plastic Surgery  
 Associates in Plastic Surgery  
 Associates in Plastic Surgery  
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Medical Transportation Association of NJ  
 Surgical Specialists of New Jersey, LLC

General Vascular Surgical Associates

Allianz Medical Group

Brecker Chiropractic Center  
 Union County Orthopaedic Group  
 The Center for Orthopedics and Sports Medicine

Central Jersey Spine Associates  
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Gregory Scott	Able Medical Transportation, Inc.
Jeffrey S. Walker	Maximum Care Ambulance, Inc.
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ARC Ambulance Service

United Surgical Partners  
 Medical Management Associates

Alert Ambulance Service, Inc.  
 Jersey Shore University Medical Center  
 Amer. Assoc. of Neuromuscular & Diagnostic Medicine

Rehabilitation Medicine Center of New Jersey  
 NJ Speech Language-Hearing Association

New Jersey Hospital Association  
 Orthopedic & Neurosurgical Specialists  
 Atlantic Orthopaedic Associates

Professional Orthopaedic Associates  
 Professional Orthopaedic Associates  
 Professional Orthopaedic Associates  
 Professional Orthopaedic Associates  
 Professional Orthopaedic Associates  
 Professional Orthopaedic Associates  
 Sandoz Chiropractic Center  
 Atlantic Health  
 Orthopedic & Neurosurgical Specialists  
 Orthopedic & Neurosurgical Specialists  
 Orthopedic & Neurosurgical Specialists  
 American Physical Therapy Association  
 American Physical Therapy Association  
 American Physical Therapy Association  
 Montclair Cardiology Group

Atlantic Orthopaedic Associates  
 Consolidated Services Group, Inc.  
 Property Casualty Association of America  
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Charles Vogel	State Farm Insurance Company
Mitchell Livingston	NJM Insurance Group

Comment: One commenter requested that the Department not adopt the proposal without conducting a public hearing or a “full airing out of the significant policy issues underlying this proposed rule.”

Response: The Department does not agree with the commenter. Prior to the formal proposal, the Department engaged in informal conferences and consultations with many interested parties concerning the medical fee schedule. When the repeals, new rules and amendments were formally proposed, copies were sent to all parties on the Department’s interested persons list for insurance-related matters. The Department also made the proposal available on its website and distributed copies prior to the date of publication in the New Jersey Register. In addition, the comment period on the proposal was extended an additional 30 days. See 38 N.J.R. 4800(a). More than 300 written comments on the proposal were received. The Department believes that a full and fair opportunity to comment has been given to interested parties.

The Department received many comment letters in response to a communication from a physician trade organization, the Medical Society of New Jersey (MSNJ). The communication urged physicians to send a personal comment letter to the Department about the proposal. The communication did not include a copy of the proposal but did include a link to the Department's web page where the text of the proposed amendments and fee schedules could be found. Since the contents of this communication were repeated in many letters and emails, the Department will address each of the statements in the MSNJ communication as a comment to the rule.

Comment: The MSNJ communication states, "DOBI is now proposing over 1,000 codes for medical services and ambulatory care ... However, most of these codes will result in dramatic decreases in existing payments to physicians."

Response: The Department disagrees that the adoption of the physicians' fee schedule would result in a significant reduction of fees paid to providers. In developing the fee schedule, the Department reviewed several sources of paid fee information including a database of proprietary information of fees paid by auto insurers in 2005. The reimbursements paid by auto insurers were higher, in some cases significantly higher, than reimbursements from other payors. The level of reimbursement paid by auto insurers was utilized to determine the level of fees set forth on the schedule.

The Department then used the Relative Value Unit (RVU) system developed at the Harvard School of Public Policy to reflect the relative differences in work, skill or costs of specific procedures. For most of the more than 1,000 Common Procedural Terminology (CPT) codes on the proposed schedule of physicians' services, 130 percent of the Medicare Physicians' Fee Schedule (MPFS) corresponded well to the 75<sup>th</sup> percentile fees paid by auto insurers. About 150 CPT codes, mainly those for surgical and pain management procedures, were adjusted to higher percentages of the MPFS

in order to reflect the fees currently paid by auto insurers for those services at approximately the 75 percentile.

Comment: The MSNJ communication states that the proposal, “although exempting Level I and II Trauma Facility surgeries from its application, sets rates for all other emergency care at 150 percent of Medicare.”

Response: This statement is incorrect. The rule states at N.J.A.C. 11:3-29.4(a) that surgical services provided in emergency care outside of trauma services are reimbursed at 150 percent of the PIP fee schedule amount, not the MPFS. The PIP fee schedule amount for such service is already at least 130 percent of the MPFS and many surgical procedures are set at a much higher percentage of the MPFS. For example, the Northern New Jersey MPFS amount for CPT code 29824 for Arthroscopic surgery to the shoulder is \$667.00 This code is on the PIP fee schedule at \$3,293.19 in the northern region. If this procedure were performed in emergency care, it would be reimbursed at \$4,939.79 or 150 percent of the PIP fee schedule amount.

Comment: The MSNJ communication states that, “There is no legal necessity to adopt these rules. DOBI is under no legal compulsion to take this action. The case relied upon by DOBI to justify its actions, *In the Matter of the Commissioner’s Failure to Adopt 861 CPT Codes and to Promulgate Hospital and Dental Fee Schedules*, 358 N.J. Super 135 (App. Div. 2003), merely addressed a procedural flaw under the Administrative Procedures [sic] Act. This case did not mandate that DOBI re-propose any fees beyond the 92 they adopted...”

Response: The Department does not agree with the commenter. Prior to 2001, the Department had always had a comprehensive fee schedule promulgated pursuant to the mandate in N.J.S.A. 39:6A-4.6. The amendments proposed in 2000 contained a comprehensive fee schedule although only 92

were adopted. Upon review, the Department has determined that adoption of a comprehensive fee schedule at this time will reduce the upward pressure on rates currently caused by the frequency of disputes and expensive arbitrations about what is the correct fee for a service.

Comment: The MSNJ communication states, “Physician payments under PIP account for only about 4 percent of premium dollars. These cuts will only be a small percentage of that. While meaningless to ratepayers, these cuts will be drastic for physicians and are unnecessary at a time when insurers are making record profits and competition is growing.”

Response: The Department does not agree with the commenter. Concerning the percentage of premium represented by the PIP coverage, as of 2004, the most recent year for which complete data is available, 15 percent of total premium dollars go toward PIP claims. A more relevant statistic is that in 2004, for every dollar of PIP premium collected, \$1.18 was paid out in PIP claims to providers. This means that the costs of medical coverage are pushing rates in general higher. The PIP medical fee schedule was intended to help control costs and insurance premiums.

The Department also does not agree that the adoption of a more comprehensive fee schedule would not benefit insureds. N.J.S.A. 39:6A-4.6(c) prohibits medical providers from billing fees that are higher than the fee schedule. This prohibition on balance billing is independent of who is paying for the service. Therefore, providers are prohibited from billing the insured in excess of the fee schedule when the limits of the PIP policy have been exhausted or when an insurer has properly denied payment for the service. The relatively few fees on the current schedule mean that many fees are not subject to this provision. The more comprehensive fee schedule will give more protection to injured persons who, for whatever reason, pay some or all of their own medical treatment for injuries sustained in an automobile accident.

Comment: The MSNJ communication states, “PIP is different than managed care. PIP payments should not be equated to payments made to physicians from managed care companies. Physicians enter into consensual relationships with managed care companies for various reasons and agree to accept their payments. It is a mutual agreement that is lacking in PIP cases.”

Response: As noted above in response to another comment, although allowed fee data that included managed care information was used in preparing the new fee schedule, the fees on the physicians’ fee schedule were determined by analyzing the amounts actually paid to providers by auto insurers.

Comment: The MSNJ communication states, “Further, accident victims are qualitatively different from other patients in the extent of their injuries, the after-care needed, the litigious nature of the circumstances and the need to have 24-hour trauma care available for them.”

Response: The Department does not agree with the MSNJ communication that the treatment of PIP patients is different from those of other patients. Treatments provided to a patient are represented for billing by the Common Procedural Terminology (CPT) codes developed by the American Medical Association. These codes simplify the reporting of treatment by describing the procedures and services performed by physicians and other health care providers and assigning them five-digit codes. Virtually all providers use CPT codes to bill for services provided and both the PIP and MPFS physicians’ fee schedules are comprised mainly of CPT codes. In addition, the CPT manual contains modifiers for CPT codes for the provider to indicate that the service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. The CPT manual does not have separate codes based on what caused the injury nor are there any modifiers that recognize that there is any change in the service or procedure performed due to the cause of the injury. Based on the foregoing, the Department does not believe that there is any

difference in the treatment provided to auto accident victims from the treatment provided to patients with similar injuries from other causes.

Comment: One commenter asked why the Department believed that it needed to propose a new fee schedule now. This commenter stated that the auto insurance market in New Jersey is stable from every perspective – accident victims are getting great care, insurance companies are making lots of money and consumers are happy because premiums are going down.

Response: The promulgation of a comprehensive new fee schedule for reimbursement of PIP medical costs is mandated by N.J.S.A. 39:6A-4.6. As noted above, PIP claim payments currently exceed the premium collected for the coverage. This means that rising PIP costs are exerting upward pressure on rates, contrary to the intent of the statute to contain the cost of PIP coverage.

Comment: A number of commenters representing hospitals stated that the proposed rule would affect patient care and that the Department should not propose such a rule without the formal review by the Department of Health and Senior Services (DOHSS).

Response: The Department does not know what the commenters mean by “formal review” by DOHSS. The Department notes that it is required by statute to consult with DOHSS in the promulgation of some rules such as the Medical Protocols rule, N.J.A.C. 11:3-4, but the legislature did not include this requirement for the Fee Schedule rule. DOHSS had the opportunity to provide input during the informal process conducted by the Department prior to formal proposal of the rule and to submit comments to the proposal.

Comment: Many commenters maintained that the proposal must be more comprehensive since it includes only a small portion of the 8,000 codes in the MPFS schedule and because inclusion of more codes will facilitate prompt payment and reduce insurer/provider disputes. Another commenter questioned why there were codes on the fee schedule that were not typically used to treat persons injured in auto accidents.

Response: The Department does not agree with the comments. As noted below in response to another comment, the Department reviewed data by CPT code on what auto insurers actually paid to providers and included every CPT code which was performed with any frequency. For procedures that are performed very infrequently, the Department did not believe that it had enough data to determine a fee to be included on the fee schedule.

Comment: The Department received many letters, including a number of form letters, that opposed “linking the PIP fee schedule to Medicare.” The commenters stated that the MPFS is based on a “flawed ‘sustainable growth rate’ (SGR) formula” and that this proposal would only expand use of a broken formula.

Response: The Department does not agree with the commenters. The PIP fee schedule is not being proposed as a percentage of the MPFS. The PIP fee schedule contains stand-alone dollar amounts. The dollar amounts on the PIP fee schedules will not change automatically and the Department does not intend to change the PIP fee schedule simply because Medicare makes changes to the MPFS. As explained in the Summary of the proposal, the Department is using the underpinning of the MPFS, the Relative Value Units (RVUs), as a basis for deciding to have a fee that is higher for one procedure than another procedure. The biennial adjustments to the fee schedule required by N.J.S.A. 39:6A-5.1 will be made independently of any changes that the Center for Medicare Services (CMS) makes to the

MPFS. Put another way, if Federal budget requirements cause the MPFS to be reduced, that will have no effect on the PIP fee schedule.

Comment: Many commenters stated that it was not appropriate to use the MPFS as a basis for the PIP physicians' fee schedule because generally Medicare patients are elective, seen during normal business hours and their treatment is not as stressful as the treatment of a traumatic patient who is sent to the emergency room late at night with a very upset family with an unexpected injury requiring immediate and complex care.

Response: The Department does not agree with the commenters. From the elderly diabetic woman who breaks her hip to a man with a heart attack requiring quadruple bypass surgery, the Medicare population has its share of emergency room visits that require complex and immediate care. In any case, as noted above in response to a previous comment, the fees on the PIP physicians' fee schedule are expressed as dollar amounts. For many surgical treatments commonly performed in emergency care on the victims of auto accidents, the fees on the PIP fee schedule range between 200 and 800 percent of the MPFS and reflect the actual amounts that are paid by auto insurers for these services.

Comment: A number of commenters stated that community hospitals are having difficulty in staffing their emergency rooms and trauma centers. The commenters asserted that this problem would be exacerbated by use of a fee schedule that is tied to Medicare. The commenters stated further that the complication rate is higher for emergency and trauma patients, which affects the physicians' practice and increases liability. The adoption of the proposed fee schedule, according to the commenters, would cause many physicians to stop taking emergency and trauma calls, with resultant harm to patients.

Response: As noted above in response to an earlier comment, the Department's fee schedule is not tied to Medicare. Moreover, the Department's physicians' fee schedule reflects what is actually being paid to providers by auto insurers, with the amounts on the fee schedule being increased by 150 percent for services provided in an emergency room. The Department has no control over the decisions of providers to take emergency calls but it does not believe that the adoption of this fee schedule will adversely affect that decision.

Comment: One commenter stated that many treating physicians are US citizens who feel a personal and professional obligation to other US citizens especially when the government is the payor. This commenter stated that physicians are willing to accept lower reimbursement for Federal programs such as Medicare since ultimately it is their money being spent. The commenter stated that no such obligation to accept lower fees is felt by physicians for highly profitable private insurance companies. The commenter stated that many physicians are able to accept Medicare and Medicaid patients because the low fees are offset by reimbursement by better paying insurers.

Response: As noted in response to a previous comment, the PIP physicians' fee schedule is not tied to Medicare and in almost all cases should not lower reimbursement for providers. The Department obtained information on the amounts actually paid to providers by auto insurers during 2005 to determine general fee levels; the RVU system was used to reflect differences in work, skill and cost to approximate the 75 percentile of the paid fees.

Comment: Some commenters cited the increases in malpractice insurance and cuts in reimbursement by other payors. These commenters also alleged that treating auto accident victims on an emergent basis when there is no relationship between the provider and the patient increases the risk of a malpractice claim.

Response: As noted above in response to the previous comment, the Department disagrees that the adoption of the physicians' fee schedule would result in a reduction of fees paid to providers. The fees on the physicians' fee schedule were determined by analyzing the amounts actually paid to providers by auto insurers. Data submitted by some auto insurers indicates that the overall level of reimbursement to providers will not decrease.

Comment: Many commenters stated that the reimbursement rate of 130 percent of the MPFS is excessive and suggested lowering the rate to 110 percent or 120 percent because this would be more in keeping with the fees in Pennsylvania and New York, and be more consistent with those in California, Texas and Hawaii.

Response: The Department does not agree with the commenters. As noted above in response to another comment, the Department determined fee levels based on what auto insurers pay for these services and used the Medicare RVU scale to rank the payments for different CPT codes.

Comment: One commenter maintained that the aggregate amount paid to providers for benefits under PIP will increase as a result of the proposed schedule, but nonetheless urged adoption of the schedule because it will facilitate prompt payment and reduce the number of disputes.

Response: The Department does not believe that reimbursement to providers will generally increase upon adoption of the new fee schedule. As discussed above in response to another comment, the Department attempted to set the fees on the schedule using the fees currently being paid to providers by auto insurers.

Comment: Several commenters expressed opposition to the proposal on the grounds that it will cost more for reimbursements for services and therefore lower the number of available physicians and force hospitals to pay more for services.

Response: The Department does not understand the commenters' suggestion that promulgation of the fee schedule would lower the number of available physicians or would force hospitals to pay more for services.

Comment: Many commenters urged the Department to promulgate a comprehensive hospital fee schedule, with a set of inpatient services, which is an important tool in cost containment.

Response: The proposed new rules and amendments only concern the fee schedules for physicians, durable medical equipment, ambulance services and ambulatory surgical centers. Therefore, the comment is outside the scope of the proposal. The Department intends to review whether a hospital fee schedule is necessary.

Comment: Several commenters noted that N.J.S.A. 39:6A-4.6 requires that the fee schedules be updated biennially and noted that this had not been done. One commenter asked for annual updates to the fee schedule and asked what process would be used?

Response: Once the comprehensive new fee schedules are adopted, N.J.S.A. 39:6A-4.6 requires that they be updated biennially for inflation. Annual updates are not required by statute and the Department does not believe that they are necessary. The Department notes that the process to create this comprehensive fee schedule began in 2005 through discussions with interested parties based on an earlier draft. Development of the schedule proposed in 2006 was based upon fee data from 2005, and the adoption process has taken almost an entire year. Now that the comprehensive fee schedule is

in place, the Department expects that periodic updates to reflect inflation can be accomplished much more expeditiously. In fact, the Department intends to propose such a change in 2008 to reflect inflation through 2007. Thereafter, the fee schedules can be updated every two years based on inflation.

Comment: Many commenters asserted that the proposed fee schedule rule does not comply with the statutory mandate that it incorporate the reasonable and prevailing fees of 75 percent of the providers in a region. Several commenters claimed that because a significant percentage of New Jersey providers do not accept and treat Medicare patients, the MPFS cannot accurately reflect 75 percent of the reasonable and prevailing rates of practitioners in the region. One commenter noted that the Department had not provided any support for its determination that a physicians' fee schedule based on Medicare's RVU scale met the standard in the statute and was therefore arbitrary. Several commenters asked for specific information regarding the informal, pre-proposal input sought by the Department as well as references to data or surveys considered by the Department during the pre-proposal stage. Some commenters also claimed that the adoption of this proposal would result in a drastic reduction in fees for providers. Several commenters wanted to learn what studies or surveys the Department considered in determining that the 130 percent reimbursement rate should be the standard at which fees are set.

Response: The Department does not agree with the commenters that the physicians' fee schedule does not meet the statutory standard. Most of the commenters asserting that the Department did not meet the statutory standard did not suggest an alternative. As noted in response to another comment, the Appellate Division upheld the Department's decision to base its PIP physicians' fee schedule on paid rather than billed fees. Sources of paid fee information are the fee schedules of various payors including government sources such as the Medicare and state Workers' Compensation fee schedules,

health care providers and compilations of paid fees by vendors such as the Ingenix “allowed fee” database. The fees on the PIP physicians’ fee schedule are higher than any of the fees in these sources.

When the Department last proposed amendments to the physicians’ fee schedule in 2000, it used the Ingenix “allowed fee” database. A number of issues with this database were raised by commenters. The Department recognized that the fees on the Ingenix “allowed fee” database may be lower than those paid by auto insurers because this database is primarily composed of fees paid by managed care organizations. The compilation of fees Ingenix had made for the Department also included higher fees in the southern area of the State than in the northern area, and Ingenix could not explain why this occurred. Finally, the Ingenix “allowed fee” database does not include sufficient data about many procedures commonly performed in treating auto injuries because such procedures are not commonly found in the claims of the health insurers that contribute to the database.

Although it obtained updated information from the Ingenix ‘allowed fee’ database for this proposal, the Department sought other sources of data for the fee schedule. These included the New York Workers’ Compensation Fee Schedule (which is also used for PIP in New York State) for Westchester County, an area similar to northern New Jersey. New Jersey does not have a separate workers’ compensation fee schedule. Workers’ compensation claims in New Jersey are handled by managed care organizations. The fee schedules used by health care payors are considered proprietary and were not available to the Department individually. However, payments by health care payors are included in the Ingenix database mentioned above.

Finally, the Department used the Medicare Physicians’ Fee Schedule as a source of data. As described more fully in the Summary to the proposal, the MPFS is comprehensive and widely

accepted. The Resource Based Relative Value Scale provides a rational basis for determining the relationship between fees for various services based on physician work and practice expenses. That scale is maintained and updated by the Center for Medicare and Medicaid Services and physician advisory panels. It should be noted that Pennsylvania uses 110 percent of the MPFS for its physicians' fee schedule for automobile insurance.

The Department originally considered setting the fee schedule at 120 percent of the MPFS since that multiplier appeared to correspond to the Ingenix "allowed fee" information and the New York Workers' Compensation Fee Schedule. In the informal conferences and consultations the Department had with interested parties prior to publishing the proposal of the rule, many participants averred that some fees set at 120 percent of the MPFS were extremely low. These included surgical and pain management procedures in particular. During this time, the Department received proprietary information about fees paid by several large auto insurance carriers. This information showed the amounts that these carriers paid to providers for treatment by CPT code during the calendar year 2004. The Department compared the fees on the draft PIP fee schedule with the fee information from the insurers. There was a high correlation with most of the fees at 130 percent of the MPFS. However, certain groups of CPT codes reflecting specialty services were reimbursed by the auto insurers at much higher levels. The Department used that data to increase the PIP fee schedule for these codes to a level equivalent to what auto insurers paid to providers for these services; the information from the insurers was updated to include 2005 payment information. The Department believes that using the fees paid to providers by auto insurers for the general fee level and using the RVU system to rank the payments by level of effort is the best way of setting fees that meet the statutory standard.

Comment: As part of its comments on the proposal, the Medical Society of New Jersey (Medical Society) undertook to make its own determination of what physicians are reimbursed for procedures under the PIP coverage. The Medical Society initially encountered difficulties in establishing a credible database of fees. It found that all of the available national databases, including Ingenix, were based on blended managed care rates, which the Medical Society concluded were not reflective of PIP reimbursements. In addition, the Medical Society found that physicians could not share information about the fees that they charged with one another because of concerns about violating antitrust statutes.

The Medical Society ultimately concluded that the only available, credible source of information on paid fees was the decisions of arbitrators rendered as part of the alternate dispute resolution process provided for PIP disputes by statute. The arbitration decisions are available on the website of the administrator of the system, the National Arbitration Forum. The Medical Society hired a health care economist to analyze the awards as a basis for determining a fee schedule.

The report of the economist's findings was submitted as a comment to the rule. The report concluded that the fee level in arbitration decisions was similar to the 75th percentile of the Wasserman Physicians' Fee Reference (PFR), a publicly available database of billed fees. The report suggested using the PRF as a basis for the fee schedule in addition to arbitration decisions.

Response: The Department appreciates the time and effort expended by the Medical Society not to simply object to the Department's methodology but to try and find an alternative. However, for the reasons outlined below, the Department does not believe that arbitration decisions can be used to create a fee schedule.

First, there are two different standards for the determination of reimbursement to providers. The Department is directed to set the fee schedule at the reasonable and prevailing fees of 75 percent of the practitioners within a region. That means that 75 percent of the providers in a region receive the amount on the fee schedule or less. Fees that are not on the fee schedule are reimbursed at the usual, customary and reasonable fee (UCR). Since no disputes about the amount of fee that is on the fee schedule result in arbitration, the arbitrators (referred to as Dispute Resolution Professionals (“DRPs” in the PIP arbitration program) typically determine the UCR fee for a code that is not on the current fee schedule. Prior to this proposal, there was no methodology for determining UCR in the Department’s rules.

Moreover, DRPs do not apply the 75<sup>th</sup> percentile standard. Based on the Department’s review of these decisions, it appears that many DRPs have interpreted case law to conclude that UCR is determined by simply looking at whatever bills a provider chooses to produce as evidence of his or her usual and customary fee. The attempts of insurers to show that the provider’s fee is not reasonable based on national fee databases of billed fees, such as Ingenix, have been rejected by the DRPs on the basis that there is no documentation on how Ingenix establishes its fee database.

The Department believes that the DRP’s method of determining the UCR by using the fees on bills selected by the provider is not acceptable. The current proposal establishes a more detailed methodology for determining UCR that includes use of national billed fee databases such as Ingenix and Wasserman to demonstrate the reasonableness of the fees submitted by the provider. Since most of the UCR fee determinations by DRPs that are reported on the arbitration administrator’s website use a methodology that the Department has determined is incorrect, these decisions cannot be used to create a fee schedule.

In addition, even if arbitration decisions could be used as a source for UCR, there are not enough arbitration decisions to establish a fee schedule that meets the 75<sup>th</sup> percentile statutory standard. The Medical Society report found that only 378 codes of the more than 1000 codes in the proposal are mentioned in arbitration decisions and only 52 of those are found in more than 100 cases. The report makes no allowance for the fact that CPT codes are often mentioned in arbitration awards for reasons other than a determination of UCR so that many of the reported awards would have no value in determining a fee amount. In fact, of the 25 CPT codes listed in the Medical Society report as appearing most frequently in arbitration decisions, 20 of the codes are on the current fee schedule.

Using arbitration decisions as the basis for a fee schedule creates other problems. By its very nature, an arbitration decision is the result of a dispute between the provider and the insurer. A fee schedule based on arbitration decisions has no way to incorporate the amounts of payments made to thousands of providers that were not disputed.

Finally, the usefulness of arbitration awards is further diminished by the fact that most arbitrations are filed by a relatively small group of providers. This means that even if there are 100 arbitration decisions using a particular code, they might only represent 10 or fewer providers, which would not represent the statutory standard of 75 percent of the providers in a region.

Acknowledging that arbitration decisions alone cannot provide the basis for a comprehensive fee schedule, the report concludes by finding a correlation between UCR fees determined in arbitration decisions and a national database of billed fees published by Wasserman. Since, as set out above, the Department finds that arbitration awards do not meet the statutory standard for setting a fee schedule, the Department also finds that use of a database of billed fees to supplement the arbitration decisions does not meet the statutory standard.

Comment: One commenter stated that the Department had not adjusted the physicians' fee schedule since 1992.

Response: The Department does not agree with the commenter. The physicians' fee schedule was adjusted in 2001.

Comment: Some commenters suggested that the Department conduct some kind of survey of providers to develop the physicians' fee schedule. One provider listed seven CPT codes for spinal surgery and solicited his colleagues to, "please review these codes, and copy and/or scan EOB's [Explanation of Benefits] which document payment in excess (preferably FAR in excess) of the proposed amount. Please note that ANY insurance payment (i.e., Commercial, Workman's Comp etc.) can be submitted. If we can document that our received payments is [sic] in excess of the proposed amount, we will be able to rectify this issue with the Department of Banking and Insurance."

Response: The Department compiled the information from the EOBs it received from physicians in response to this request. The result shows clearly why a physician survey would not be a practical method to compile a fee schedule. Even accounting for the fact that the physicians were asked to submit only those EOBs with fees that were in excess of the Department's proposed fee schedule, there is a tremendous variation in the billed fees among physicians in the same geographic area. For code 22554, Dr. C billed \$24,050 while Dr. D billed only \$10,500, a difference of nearly \$14,000. For the same code, the variation in what insurers paid was even greater: \$4,571 to \$18,087. For code 63075, Dr. D billed \$9,600 while Dr. C billed \$27,794, nearly three times as much. In fact, between May and December, 2006, Dr. C billed three different amounts for the same code: \$17,794, \$25,050 and \$27,794. The insurer reimbursement recorded on the EOB's for code 63075 varied from \$1,710 to \$12,800.

The Department believes that this kind of variation between what different physicians bill for the same service and what a physician receives for the service from different payors makes it impossible to determine by a survey of any kind the prevailing fees of 75 percent of providers within a region. As noted above in response to another comment, the Department believes that its physicians' fee schedule meets the statutory standard of the prevailing fees of 75 percent of providers because it is based on what automobile insurers actually pay providers. Reimbursements by auto insurers are higher than those paid by the payors of the majority of healthcare reimbursements: Medicare; workers' compensation carriers and health insurance and managed care plans. Moreover, PIP medical care reimbursements comprise less than 3 percent of total healthcare payments in New Jersey.

Comment: Several commenters inquired why the Department did not provide any inflation analysis as required by the statute and as specifically referenced in prior amendments to the medical fee schedule and why all the schedules have not been reviewed biennially.

Response: The Department did not provide any inflation analysis in the proposed amendment because it was not adjusting an existing fee schedule for inflation but rather establishing a new fee schedule. However, the Department recognizes that the physicians' fee schedule is based primarily on data from 2005, although it reflects the two percent increase in the MPFS in 2006. The Department intends to propose an inflationary adjustment to the physicians' fee schedule in the near future. The Department has not reviewed all the fee schedules biennially as required by statute because the medical fee schedule and the three other fee schedules adopted in 2001 were subject to litigation until 2003. Since then, the Department has been developing the proposed comprehensive physicians fee schedule.

Comment: One commenter indicated that reliance on data for "paid or allowed" fees databases is faulty because it is not based on inflation and the rising Consumer Price Index, but rather on an

artificial ceiling placed on providers by fee schedules, and will therefore always stay the same or decrease.

Response: The Department does not agree with the commenter. As noted above in response to another comment, inflation is to be used in the biennial adjustments to the fee schedule. The standard for setting a fee schedule is the reasonable and prevailing fee at the 75<sup>th</sup> percentile. As discussed more fully in response to another comment, the Department has set the fee schedule as closely as possible at the fee levels currently being paid by auto insurers. Once the fee schedules have been adopted, they will be adjusted for inflation according to the statutory timeframe.

Comment: Several commenters noted that Ingenix may be a biased source in providing fee data because it is wholly owned and/or controlled by an insurance carrier, and that referencing Ingenix and Wasserman is an improper attempt to delegate authority by the Department.

Response: The Department does not agree with the commenters. N.J.S.A. 39:6A-4.6 specifically authorizes the Department to use a proprietary purveyor of fee schedules. In addition, the Department used a number of sources, in particular, a listing of amounts paid to providers by auto insurance companies, to compile the physicians' fee schedule. Many physicians have told the Department that they use fee analyzers from Ingenix to set their fees. Concerning the "delegation of authority" by the Department to Ingenix or Wasserman, the Department does not agree that its consideration of the Ingenix data is improper. As discussed more fully below in response to another comment, the Department believes that the determination of whether a provider's fee is "reasonable" can be determined by reference to these compilations of billed fees that are commercially available.

Comment: One commenter urged that the language at N.J.A.C. 11:3-29.1 be clarified. The commenter urged reinstatement of the original language to reflect that the services described in N.J.A.C. 11:3-29.1(c)3 and 4 are not subject to a fee schedule but rather subject to UCR.

Response: The Department does not agree with the commenter. The rule does not explicitly apply to the entities mentioned in N.J.A.C. 11:3-29.1(c)3 and 4.

Comment: One commenter noted that the proposal utilized a definition of two regions to be consistent with Medicare. Medicare usually does not cover dental services and the commenter urged that reimbursements based on the existing three regions are more equitable for dentists and should be retained. Another commenter observed that the Medicare regions are defined as I and II, yet in the Exhibits in the Appendix, the fee schedules are labeled “North” and “South.” The commenter recommended that consistent labeling should be used throughout the rule.

Response: The Department agrees with the commenter that since the Dental Fee Schedule, Appendix, Exhibit 2, was not amended in this proposal, it must continue to use the same three regions as in the existing rule. The Department also agrees that the reference to the regions in the proposed amendment and those in the Exhibits in the Appendix are not consistent. The Department has amended the rule upon adoption to retain the definition of the current three regions for the Dental Fee Schedule. For the definition of the regions that apply to the Physicians, Ambulance and Ambulatory Surgical Center Fee Schedules, the Department has amended the rule upon adoption to refer to them as the North and South regions. This will avoid confusion with the Regions I, II and III used in the Dental Fee Schedule and make the designation of the Regions for these fee schedules in the rule text consistent with that in the Exhibits. The Department has also corrected errors in the list of zip codes that comprise the regions.

Comment: Many commenters urged that the definition of ambulatory surgery facility (ASC) should note that a physician-owned single operating room should also be recognized as an ASC. Another commenter noted that there does not seem to be any basis for making the distinction that the facility be a separately run unit. One commenter suggested that the phrase “in an office setting” be deleted from the definition because it would provide an excuse for insurers to conduct fishing expeditions to find grounds to withhold payment on the basis of non-compliance with the “office-setting” requirement.

Response: The Department does not agree with the commenters. The definition of an “ambulatory surgical facility” (ASC) in N.J.A.C. 11:2-39.2 comes in part from the rules of the Department of Health and Senior Services, which requires that to be licensed, the facility where surgical cases are performed must be separate and apart from any other facility licensee, such as a hospital. The other part of the definition comes from the definitions of “operating room” and “office” in the rules of the Board of Medical Examiners at N.J.A.C. 13:35-4A.3. In addition, such facilities must be certified by Medicare.

Comment: The Department received a number of comments from hospitals and hospital trade organizations concerning the exemption from the fee schedule for services provided in Level I and Level II trauma hospitals. These commenters objected to the Department’s attempt to limit the exemption from the fee schedule to service provided in the “trauma unit” of the hospital. The commenters pointed out that there is no definition of “trauma unit” in law or regulations. The commenters argued strongly that the exemption should continue to apply, as it does now, to all inpatient services provided to patients who are treated by the trauma physicians. The commenters noted that actual trauma care is rendered throughout the hospital setting. The commenter predicted that the proposed change in the definition would have serious financial consequences to New Jersey’s

system of providing trauma care. One commenter suggested alternative language that would differentiate routine emergency room patients from those patients that are evaluated and treated by the trauma physicians in the ten hospitals designated as Trauma Centers.

Response: The Department appreciates the commenters clarifications with regard to how trauma services are provided in a hospital designated as a trauma center. The rule has been amended upon adoption to continue the exemption for all physician services provided by the trauma services in hospitals designated as trauma centers, and to clarify the exemption by using the language suggested by the commenter for differentiating between routine emergency care and trauma services.

Comment: One commenter requested clarification on how surgical services performed in the emergency room but that are not on the physicians' fee schedule would be reimbursed. The commenter noted that the rule provides that surgical services performed in the emergency rooms of hospitals that are not designated as trauma centers will be reimbursed at 150 percent of the fee schedule.

Response: Any medically necessary service that is not on the fee schedule will be reimbursed at the usual, reasonable and customary fee for the service as billed by the provider and reviewed the insurer.

Comment: One commenter asked for confirmation that the definition of emergency care at N.J.A.C. 11:3-29.2 means that surgical services are reimbursed at the higher fee amounts provided by N.J.A.C. 11:3-29.4(a) throughout the acute care phase of treatment.

Response: The commenter's interpretation is correct.

Comment: One commenter requested that the Department clarify how physician services provided to PIP patients in emergency rooms of general acute care hospitals will be reimbursed.

Response: The Department believes that the rule does not require any clarification. Surgical services provided to PIP patients in the emergency rooms of general acute care hospitals are reimbursed at 150 percent of the fee schedule amount; non-surgical services are reimbursed at the fee schedule amount; and, as noted above, services that are not on the fee schedule are reimbursed at the usual, customary and reasonable fee.

Comment: One commenter asked why trauma doctors are now removed from the fee schedule since the same arguments submitted on their behalf would apply to other physicians as well who have a high risk of malpractice because of the nature of their practice.

Response: The reason that physician services provided in the trauma units of New Jersey's trauma centers continue to be exempt from the fee schedule is not because of malpractice premiums but because the staffing requirements for trauma centers have inherently higher costs that should be reflected in the level of reimbursement. The Department recognizes that the reimbursement for PIP claims for serious or catastrophic injuries is critical to support New Jersey's trauma center hospitals.

Comment: Some commenters asserted that setting the fees for surgical services performed in emergency rooms at 150 percent of the fee schedule may lead to unintended consequences, whereby surgeons may refer their patients to meet them at the emergency room for care, seeking the higher reimbursement. This result would clearly not further cost containment.

Response: The Department does not believe that such an outcome is likely since to be eligible for the higher fees, the surgery must be performed during emergency care as defined in the rule. Most surgical procedures are scheduled for patients who are not currently admitted to a hospital and who do not risk death without immediate treatment.

Comment: The Department received many comments about N.J.A.C. 11:3-29.4(e), the definition of the usual, reasonable and customary (UCR) fee for services that are not on the fee schedule. These commenters objected to the definition of “usual and customary” fee to be “the amount that the provider is reimbursed for the service by all payors,” pointing out that providers receive different payments from payors depending on whether a discount has been negotiated. The commenters claimed it would be impossible for the provider to submit a bill that met the requirements of this provision. The commenters stated that the provider should be required to submit his or her usual and customary fee. Another commenter stated that in the Summary to the rule, the Department referenced the case, *Tito Cobo v. Market Transition Facility*, 293 N.J. Super, 374 (App. Div. 1996), in a way that exceeded the holding in the case and tried to codify an expanded role for the payor in determining UCR.

Response: The Department agrees with the commenters that because of the myriad of different payors, it would be difficult for a provider to bill the amount that he or she ordinarily is reimbursed for a service. The Department is amending the rule upon adoption to delete the quoted last phrase from the rule. The Department does not agree with the commenters on how the “reasonableness” of a fee is determined. The *Cobo* case stated:

“Against this background of legislative and regulatory development, we consider defendant's claim that the trial court erred in determining HPTS met its burden of proving its fees were "reasonable" in the six test-cases because HPTS adhered to the fee schedules. In *Thermographic, supra*, 125 N.J. 491, our Supreme Court discussed the meaning of "reasonable" medical expenses in the context of the medical fee schedules. Agreeing with this court, the Supreme Court decided that the "customary and prevailing" fees for thermography "should not be conclusive in determining whether those fees are reasonable." *Id.* at 516. Thus, the Court remanded the matter to the trial court for a determination of the reasonableness of plaintiff's rates, "which should not be determined solely on the basis that they are consistent with the prevailing rates." *Id.* at 518. Applying this approach, we are satisfied that the trial court mistakenly concluded that HPTS's fees were reasonable simply because they conformed to the PIP fee schedule rates. The court should have used the schedules

as no more than evidence of reasonableness, and should have considered other factors, such as what other physical therapists were charging for the same services, HPTS's billing history, and the disparity in the fees charged to different insurance carriers.” *Cobo, supra*, 293 *N.J. Super.* at 387.

The Department believes that the *Cobo* case affirms that the role of the payor is not simply to pay whatever the provider bills but to make a determination of whether the provider’s bill is reasonable compared to other providers in the region. The Department recognizes that obtaining information about what other providers bill and receive for the same service may be difficult. As noted in response to a previous comment, the Department received evidence that some providers apparently bill different fees to different payors. Providers unquestionably receive different amounts from different payors. Therefore, bills produced by the provider as evidence of usual and customary may have little value. To address this problem, the rule specifically recognizes two national databases of fees to be used in the determination of reasonableness. Although these databases are compiled from surveys of billed fees and cannot be used to compile the fee schedule, they are a resource in determining UCR. It should be noted that the fees in these databases are expressed as percentiles. That is, a fee that is in the 95<sup>th</sup> percentile means that 95 percent of providers bill that fee or less. The Department notes that in its study, the Medical Society determined that the 75<sup>th</sup> percentile of the Wasserman billed fee compilation approximates the UCR determinations made in the arbitration awards it reviewed.

Comment: Several commenters recommended that the Department use the definition of UCR found in the “Minimum Standards for Individual Health Insurance” rule, N.J.A.C. 11:4-16.8, which states that, “usual means the fee ordinarily charged by the provider for a particular service or supply; customary means the range of usual fees charged by providers for the same service or supply under like circumstances within the geographic region;

reasonable means a fee above usual and customary, which is justified by unusual complexity of the treatment required.”

Response: The Department does not agree with the commenters. First, the use of “reasonable” in the Minimum Standards rule definition is replaced in the fee schedule rule by the use of modifiers to CPT codes to indicate additional services provided. Second, the description of “customary” in the Minimum Standards rule definition is basically the same as the definition of “reasonable” in the fee schedule rule. Therefore, the Department does not see any advantage in using the definition of UCR in the Minimum Standards rule.

Comment: One commenter referred the Department to decisions of the PIP Dispute Resolution Professionals (DRPs) that refused to accept the Ingenix database as evidence of UCR because Ingenix will not release information on how the schedule was compiled.

Response: The decisions by DRPs mentioned by the commenter are the reason that the Department amended the rule to specifically include the Ingenix and Wasserman databases. Some DRPs have ruled in the past, that because Ingenix has not disclosed to their satisfaction how it determines its percentile rankings, Ingenix cannot be used as evidence of what constitutes UCR. This ignores the fact that Ingenix designs this product for providers and sells it to help them set the fees that they bill.

Comment: Some commenters believed that the 75<sup>th</sup> percentile standard in N.J.S.A. 39:6A-4.6 should be applied to the determination of the UCR for fees that are not on the fee schedule.

Response: The commenters are incorrect. As noted in response to a previous comment, the 75<sup>th</sup> percentile standard is for development of the fee schedule. The statute is silent on how UCR for services not on the fee schedule is to be determined. Nevertheless, the Department recognizes the advantage of obtaining additional data about the level of fees paid by auto insurers in connection with

future development of the fee schedules. Therefore, the Department expects to require reporting by auto insurers of information on fees paid in a future amendment to its rules. Reporting of fees paid will enhance the accuracy and consistency of the schedule as it is amended periodically.

Comment: Several commenters recommended that the language at N.J.A.C. 11:3-29.4(e)1 be strengthened regarding the validity of national database information to determine the reasonableness of fees in a provider's region or zip code. Many commenters urged that the databases referenced in the rules should be presumed acceptable or create a presumption of acceptability and therefore be deemed a legally binding definition of UCR. In the alternative, it was suggested that a certain percentile be specified as UCR and that this approach would avoid arbitration and disputes.

Response: The Department believes that the inclusion of the databases in the rule establishes their evidential value in determining UCR. The Department has not established a percent of the national databases in this proposal. The use of the national databases will enable payors to compare a provider's bill to what is charged by other providers in the region, and provide probative evidence for use by DRPs in resolving disputed fees.

Comment: One commenter asked for clarification on what Ingenix database the Department was referring to in calculating UCR. The commenter noted that the Department had referred in the Summary of the proposal to the allowed fee database maintained by Ingenix.

Response: In mentioning databases that payors can use to demonstrate the reasonableness of a provider's fee, the Department intended to refer to compilation of fee information by geographic area available to and used by many payors and providers in setting their fees, such as the Ingenix MDR™ Payment System and the Ingenix Fee Analyser. The allowed fee database maintained by Ingenix is proprietary and is not generally made available to the public.

Comment: One commenter noted that Medicare has two fees for certain codes, a Facility Fee and a Non-Facility Fee. The Facility Fee rate is lower, reflecting the fact that physicians in facilities, including ASCs, have lower practice costs. The fee schedule is a multiple of the higher Medicare Non-Facility Fee. The commenter suggested that the PIP fee schedule ought to reflect the lower practice costs for physicians in ASCs.

Response: The comment is the first time this issue has been raised with the Department. As noted in response to other comments, the Department is not basing its fee schedule on that of Medicare but is using Medicare's Resource Based Relative Value system to determine the relationship between fees for various services based on physician work and practice expenses. The amount of the fees on the physicians' fee schedule is based on a variety of data including what auto insurers are actually paying for these services. At this time, the Department does not believe that it is necessary to have a two-tiered physician fee schedule based on facility and non-facility fees. The Department invites the commenter to provide additional information about why it should make such a change and in particular, whether payors other than Medicare make this distinction.

Comment: One commenter suggested that the Department adopt the Resource Based Relative Value (RBRVS) coding guidelines in addition to adopting the National Correct Coding Initiative (NCCI) edits.

Response: The Department will review the RBRVS coding guidelines and may include them in future rulemaking.

Comment: One commenter inquired who is responsible for ranking surgical procedures in descending order where there are multiple surgeries, and what should be done if the highest cost is a UCR fee? Another commenter maintained that reliance on Medicare standards to determine fees for multiple and

bilateral surgeries and utilizing co-surgeons and assistant surgeons is too restrictive. The commenter noted that the standard in the existing rule relies on American Medical Association (AMA) terminology and publications in the provider specialty and urged continuation of that standard. Another commenter inquired whether proposed changes to N.J.A.C. 11:3-29.4(f)3 mean that the Multiple Procedure Reduction formula will now apply to all surgical procedures performed in a surgical setting, regardless of body region. Another commenter noted that while the Department utilized the AMA CPT code descriptors, it deviates on the definition of co-surgery. The commenter recommended that the AMA standard be incorporated.

Response: The Department agrees with the commenter with respect to the situation where one of the multiple or bilateral procedures is not on the fee schedule. The rule will be amended upon adoption to indicate that, for purposes of determining the multiple procedures reduction formula, the procedures should be ranked in descending order by fee amount, either using the fee schedule or UCR amount, as applicable. The Department does not agree with the commenter that the previous restrictions on multiple and bilateral surgeries came from AMA standards. The Department has always based its multiple and bilateral procedure rule on Medicare guidelines. The Department does not know to which AMA guidelines the commenter is referring, other than very brief descriptions in the CPT manual.

Comment: One commenter sought a relaxation of the bilateral procedure reduction when essentially the same time and intensity is spent on the one operative session as would be on two separate sessions and provided specific language to be incorporated into the rule.

Response: The Department does not agree that the Medicare standard reflected in the paragraph is too restrictive. The commenter has not provided any support for the suggested change. In addition,

amending the rule upon adoption with the commenter's suggested language would be a substantive change requiring additional notice and public comment.

Comment: One commenter asked whether the procedure for overpayment of a co-surgeon or assistant surgeon because of lack of modifiers on a primary surgeon's bill in N.J.A.C. 11:3-29.4(f)7 is also applicable to overpayment on the technical and professional components of diagnostic procedures.

Response: The billing and payment of CPT codes that have global, technical and professional components could result in situations similar to that addressed in N.J.A.C. 11:3-29.4(f) 7. The Department needs additional information to determine if incorporation of such a procedure would be appropriate in future rulemaking.

Comment: Several commenters sought clarification regarding reimbursement for co-surgeons using Modifier 62. Is reimbursement to each 62.5 percent of eligible charges or is 150 percent of a single practitioner's eligible expenses to be divided by two surgeons? Another commenter requested guidance on payment in a situation in which multiple surgeries are performed and one is bilateral.

Response: According to the Medicare Claims Processing Manual, when co-surgeons bill using the -62 modifier, each one is paid 62.5 percent of the eligible charge. N.J.A.C. 11:3-29.4(f)1 addresses the circumstance where multiple surgeries are performed and one is bilateral. It states, "If any of the multiple surgeries are bilateral surgeries using the modifier '-50,' consider the bilateral procedure at 150 percent as one payment amount, rank this with the remaining procedures, and apply the appropriate multiple surgery reductions."

Comment: A commenter inquired why the Department has eliminated the 25 percent category of the multiple procedures reduction formula.

Response: As set forth in the Summary to the Proposal, the Department has consistently applied Medicare Claim Processing rules to its fee schedule. Originally, Medicare used a 100/50/25 percent multiple procedure reduction formula. The Medicare rule was later changed to 100/50 percent reduction formula. The Department is changing its rules to follow the Medicare rules.

Comment: Several commenters sought clarification regarding the National Correct Coding Initiative (NCCI) edits and inquired whether they take precedence over the AMA/CPT coding guidelines; whether their incorporation into the rules is without statutory basis and would be unduly burdensome and costly for providers; and whether the use includes both mutually inclusive and exclusive edits.

Response: The NCCI edits were initially based on the AMA/CPT coding guidelines. The Department does not believe that the two systems should conflict. However, if they do, the NCCI would take precedence. The Department believes that it has sufficient statutory authority to use the NCCI to prevent overpayment of medical services. The fee schedule rule has always contained a prohibition on unbundling that was based on a similar prohibition used in Medicare. Adoption of the NCCI simply makes the auto fee schedule current with Medicare practices on this issue. Adoption of the NCCI includes both mutually exclusive and inclusive edits. The Department does not believe use of the NCCI should be burdensome on providers. Providers are not required to bill their services any differently. However, payors can use the edits to deny payment for bills that are not coded in accordance with the edits.

Comment: One commenter noted that the website indicated in the rules for NCCI is incorrect and questions the Department's reliance on this reference.

Response: The Centers for Medicare and Medicaid Services have apparently changed the page referenced in the proposal. The Department has amended the rule upon adoption to include the correct URL .

Comment: One commenter urged that N.J.A.C. 11:3-29.4(g)5 be amended to permit dentists who hold parenteral conscious sedation permits pursuant to N.J.A.C. 13:30-8.2 to bill separately and be reimbursed for sedation. The commenter noted that separate reimbursement for this service is the norm in dentistry.

Response: The Department needs additional information as to whether an exception from the rule requirement should be made for dentists. If the Department concludes that such amendments are warranted, an exception from the requirement will be added in future rulemaking.

Comment: Several commenters inquired whether N.J.A.C. 11:3-29.4(g)6 applies to a second physician if the second physician is employed by a physician performing diagnostic/therapeutic services or the facility?

Response: The Department does not understand how a possible employment relationship of the second physician would affect how the codes are billed.

Comment: One commenter stated that the new language regarding Nerve Conduction Studies (NCV) expressly violates the rules of the Board of Chiropractic Examiners and is aimed at preventing chiropractors from performing an NCV test. The commenter noted, that to the extent that the Department's concern is that the NCV and needle EMG be performed on the same day, it should state so.

Response: The Department assumes that the commenter is referring to the use of the word “physician” in N.J.A.C. 11:3-29.4(h). It is within the scope of practice for a chiropractor to perform a nerve conduction study. The Department is amending the rule upon adoption to substitute “provider” for “physician.”

Comment: One commenter stated that N.J.A.C. 11:3-29.4(h), which states that to be reimbursable, nerve conduction studies must be interpreted by the physician who was onsite and directly supervised or performed the study, is unnecessary because performance of these studies by anyone other than a physician is already prohibited by New Jersey law. Another commenter claimed that the requirement that the interpreting physician be on site and directly supervise or perform the nerve conduction study is a requirement that does not exist for MRIs or x-rays, and is not required by the rules of the Board of Medical Examiners (BME) or the Chiropractic Examiners.

Response: The BME regulation at N.J.A.C. 13:35-2.6(n)3, requires that, “Direct physician presence, supervision and interpretation is provided for all diagnostic tests which, although not invasive, require a sequential analysis with respect to the extent of medically necessary testing, for example, nerve conduction studies, somatosensory evoked potentials, and similar studies.” The Department does not believe there is any problem with the similar provision in the proposal but is amending the rule upon adoption to include a reference to the Board of Medical Examiners rule. The Department does not agree with the comment that physician presence is not required by BME rule for nerve conduction studies. These studies differ from x-rays and MRI’s that produce an image that can be examined after the study is done. As noted by the BME rule, nerve conduction and other similar studies require an analysis at the time the study is being done.

Comment: One commenter urged the Department to clarify the language in N.J.A.C. 11:3-29.4(k) that the paragraph applies only to CPT codes whose description is “unlisted procedures or services” rather than to all services not listed on the fee schedule. For CPT codes with a description other than “Unlisted procedure or services,” UCR applies if not on the fee schedule.

Response: The Department agrees with the commenter that it is not clear that the language in the proposal requiring justification refers to the “xxx99” codes in CPT that include the description, “unlisted procedure or services.” None of these codes is on the fee schedule so they would be reimbursed at UCR. The rule has been amended upon adoption to make this clear.

Comment: Several commenters urged that pre-certification be mandated rather than merely encouraged under N.J.A.C. 11:3-29.4(k).

Response: The Department does not agree that such a requirement is necessary at this time.

Comment: Several commenters supported the proposal of additional codes within the daily maximum set forth in N.J.A.C. 11:3-29.4(m).

Response: The Department appreciates the support.

Comment: The commenter noted the amendments to language in the rule designed to exempt treatment of serious injuries. The commenter believed that even with the amended language, there was still the potential for disputes about how much treatment is necessary for any particular patient. The commenter suggested that the rule include a list of specific diagnoses identified by ICD-9 code that are exempt from the daily maximum when treatment is being provided in a hospital-based setting. The commenter provided a list of such diagnoses.

Response: The Department believes that the concept of exempting patients with certain diagnoses from the daily maximum is worthy of further consideration. The Department wishes to consult with other users of the system about making such a change. If the Department determines that use of diagnosis codes would be helpful, it will propose an amendment to the rule to include them.

Comment: Several commenters claimed that there needs to be a better definition of what types of injuries allow a reimbursement of more than the \$99.00/day maximum and sought a list of which injuries can be billed with a Modifier 22. Several commenters suggested deletion of the provision that permits paying more than the maximum under certain circumstances since this provision can be a basis for frequent disputes. Several commenters stated that the amendment to the rule for reimbursement in excess of the daily maximum is inappropriate and unnecessary.

Response: The Department notes that the commenter who requested a better definition of injuries the treatment of which would not be subject to the cap did not provide any suggested alternatives. As noted above in response to another comment, the Department will consider using ICD-9 diagnosis codes to develop a list of the types of injuries that can be billed with a Modifier 22. The Department does not agree that the exemption should be deleted because it may be the basis for disputes. There are cases in which application of the daily maximum is not appropriate and it would not be fair to the provider or the patient to have an inflexible daily maximum simply to avoid disputes.

Comment: Does the existence of a non-care path related diagnosis, in addition to a care path diagnosis, demonstrate a high enough level of severity to warrant additional reimbursement?

Response: The Department believes that including a non-care path related diagnosis in addition to a care path diagnosis would result in too broad a definition of injuries whose treatment should exceed the daily maximum. The diagnoses that have care paths were determined by their frequency in claims,

not their severity. There are other soft tissue diagnoses that do not have care paths and for which it would not be appropriate to exceed the daily maximum. As noted in response to a previous comment, the Department believes that it may be more appropriate to establish a list of specific diagnoses, for which treatment would be exempt from the daily maximum.

Comment: Many commenters expressed support for the increase in the daily maximum from \$90.00 to \$99.00

Response: The Department appreciates the support.

Comment: Several commenters stated that a \$9.00 increase from \$90.00 to \$99.00 after 6 years was proposed without any analysis or basis for the increase. Many commenters requested that no increase from \$90.00 to \$99.00 be implemented unless there is credible data to substantiate the increase.

Response: The Department believed that it was appropriate to raise the amount of the daily maximum because it has added additional codes to those subject to the daily maximum. The Department notes that the daily maximum far exceeds the amount paid for similar services by many health insurers.

Comment: Many commenters urged that osteopathic manipulation should not be included under the proposed \$99.00 daily maximum because it inadequately compensates the doctors and should remain separate and distinct. The commenters maintained that inclusion in the cap will force many doctors to stop treating PIP patients. One commenter noted that application of the cap to osteopathic manipulation treats osteopathic manipulation as a physical therapy service which is inconsistent with Medicare, which does not cap osteopathic manipulation on its list of capped physical medicine services.

Response: The Department does not agree with the commenters. The daily maximum is for treatments commonly provided together. Osteopathic manipulative treatment (OMT) is not typically done together with the other treatments that are on the list of CPT codes that are subject to the cap. No OMT treatment on its own would exceed the cap. However, if a provider is providing OMT in conjunction with the other CPT codes that are subject to the cap, then it is appropriate to apply the cap. The daily maximum does not apply to other treatments that may be provided by osteopaths, who are plenary licensed physicians.

Comment: One commenter from a multidisciplinary practice of physical therapy and chiropractic stated that his patients could not receive treatment from different disciplines for different injuries because of the daily maximum. The commenter suggested that the rule be amended to make the \$99.00 maximum apply per discipline per day.

Response: The Department acknowledges that a patient who has injuries to two or more different parts of the body, both or all of which require treatment that is subject to the daily maximum, may have to make multiple visits to providers. The Department believes that the beneficial effects of the daily maximum in preventing excessive charges by unbundling of services commonly provided together are outweighed by the inconvenience to relatively few patients. However, as was noted in the Summary to the proposal, the Department will continue to examine whether the daily maximum is the best way to address the issue of unbundling of physical medicine and rehabilitation services.

Comment: One commenter objected to CPT 97530 (Therapeutic Activities) being included in the codes subject to the daily maximum. The commenter stated that the Department should encourage conservative treatment in pain management rather than invasive surgical procedures and injections.

Response: The Department agrees with the commenter that conservative care options should be explored in pain management before invasive procedures. The Department does not believe that including CPT 97530 in the daily maximum prevents it from being used for this purpose.

Comment: One commenter claimed that the proposal discriminated against physical medicine and rehabilitation specialists. The commenter stated that he received higher reimbursement from Medicare for his services to patients whose injuries were not as serious as those of persons injured in motor vehicle accidents and without the burden of precertification and other hurdles to receiving payment.

Response: The Department does not agree with the commenter. Medicare does not use the same type of controls on overutilization as are used by auto insurers. Instead, Medicare uses limits on the number of covered services. In addition, the Center for Medicare and Medicaid Services has recently identified physical medicine and rehabilitation services as one of the fastest growing types of services billed to Medicare and has recommended a corresponding reduction in fees to address this issue.

Comment: The Department received several comments on N.J.A.C. 11:3-29.4(m)5, which repeats the requirement found in N.J.S.A. 39:6A-4 that physical therapy treatment must be performed by a physical therapist pursuant to a referral. Several commenters supported the inclusion of this provision in the rule. Some commenters inquired whether physical therapy modalities billed by a provider other than a physical therapist will be reimbursable. Other commenters urged that the Department provide clear guidelines for what modalities will only be reimbursable to physical therapists. One commenter suggested the Medicare rules be used for this purpose. One commenter stated that requiring referral for physical therapy services under PIP was not consistent with Physical Therapy Practice Act, which permits physical therapists to treat without a referral. Many commenters pointed out that the Physical Therapist Licensing Act at N.J.S.A. 45:9-37.19 has a restriction similar to that of N.J.A.C. 11:3-

29.4(m)5, but permits other licensed professionals to engage in the practice for which they are licensed provided that they do not hold themselves out as physical therapists or physical therapist assistants unless they are so licensed.

Response: P.L. 2003, c. 18 amended the Physical Therapy Practice Act to permit physical therapists to provide treatment without a referral from another medical provider. However, that law specifically exempted physical therapy provided under the PIP coverage from direct access by also amending N.J.S.A. 39:6A-4. The language of N.J.S.A. 39:6A-4 is reproduced in the rule at N.J.A.C. 11:3-29.4(m)5. Therefore, the commenter's statement that N.J.A.C. 11:3-29.4(m)5 is inconsistent with direct access is incorrect. The Department does not construe the language of N.J.A.C. 11:3-29.4(m)5 to prohibit providers other than physical therapists from administering any particular modalities. Rather, the statute states that other licensees cannot refer to their services as physical therapy. Since physical therapy treatment is defined at N.J.S.A. 45:9-37.13, that reference was included in the rule. The Department appreciates the support of the commenters.

Comment: Several commenters suggested that services rendered by a physical therapist assistant under the supervision of a licensed physical therapist be included in N.J.A.C. 11:3-29.4(m)5.

Response: The Department does not agree with the commenters. As noted above in response to another comment, the statutory language reproduced at N.J.A.C. 11:3-29.4(m)5 was an exception from direct access to patients for physical therapists. The referrals that it requires would not be made to physical therapy assistants. The language in the regulation does not prevent physical therapy assistants from treating patients injured in auto accidents under the supervision of a physical therapist who has a referral from another medical provider.

Comment: One commenter suggested that the Department include in the fee schedule rule a prohibition against a physical therapist splitting fees with a referring provider based on the language in N.J.S.A. 45:9-22.5 and 45:9-37.21.

Response: The Department does not agree with the commenter that such a provision should be included in these rules. Licensees are subject to a number of statutes and rules that govern their profession and it is not necessary that they all be reiterated in the fee schedule rule.

Comment: One commenter urged the Department to define the term “supervised modality.”

Response: In the AMA’s CPT publication, modalities that are listed as “supervised” are defined as, “[T]he application of a modality that does not require direct (one-on-one) patient contact by the provider.” The Department does not believe a definition in these rules is necessary.

Comment: One commenter noted that the proposal’s discussion concerning the proper code for reimbursement of unattended electrical stimulation is unnecessary because the Department is proposing to rely on the NCCI for billing and that would require G0283 rather than 97014.

Response: The commenter may be correct, however, the Department does not believe that there is any inconsistency with including the provision in the rule.

Comment: Several commenters sought the basis for setting the amount of the facility fee for ambulatory surgical centers (ASCs) at 300 percent of the Medicare base rate and maintained that this number was severely inflated and out of step with the rest of the fee schedule. Other commenters stated that the ambulatory surgical center fee schedule was too low and did not incorporate the reasonable and prevailing fees of 75 percent of the providers.

Response: The Department believes that it has set the ASC fee schedule at an appropriate level. It notes that there has been a substantial increase in the utilization of ASCs as the setting for a wide variety of treatments during the past few years, and that the number of ASCs licensed by the DOHSS has been steadily increasing. Explosive growth of these treatment settings as a less expensive option to hospital treatment is thus a relatively new phenomenon. The proprietary paid fee data for auto insurers shows a wide range of fees for similar services, and thus the determination of an appropriate reimbursement level requires reference to a broader array of data, noting that the fee reimburses a facility, rather than a provider, for certain common services.

As to the general level of the fees in the proposal, Medicare recently instituted a service called the Transparency Initiative that is intended to provide people with access to information that will facilitate their shopping for medical services. It shows by State and by county how much ASCs bill Medicare for a number of commonly performed services and what Medicare pays. The only procedure that is on the auto fee schedule and the Medicare Transparency Initiative list is a spinal injection code: CPT 64476.

The amounts billed by ASCs for this code range from a low of \$350.00 in Sussex County to a high of \$3,153 in Essex County. By way of comparison, the facility fees on the Department's proposed schedule are: \$1,265 for North Jersey and \$1,171 for South Jersey, which is comparable to or more than most of the billed ASC fees as shown by the Medicare data. The Department notes that fees paid to ASC's by most non-auto payors, including Medicare, are substantially less than the billed amount. The Department also received from an insurer some examples of facility fees that were billed for PIP patients for the same code. The fees ranged from \$1,150 to \$3,000, similar to the high end of the fees billed to Medicare.

The Medicare Transparency Initiative is important because there is not a great deal of available information on what facility fees ASCs in non-PIP situations are charging other payors. Although created as a lower-cost alternative for minor surgical procedures that were performed in hospitals, some ASC providers have taken advantage of the fact that they have been subject to little regulation and have charged exorbitant facility fees. Fraud in ASCs was the subject of a recent Symposium given by the Office of the Insurance Fraud Prosecutor (OIFP) and an article on the subject was included in the 2006 Annual Report of the OIFP.

Comment: Several commenters noted that Medicare has proposed a new system for paying ASC fees that will begin in 2008 and suggested that the Department should not adopt the proposal and repropose rules using the new system.

Response: The Department does not agree with the commenters that it should not adopt the proposed fee schedule for ASC's until the new Medicare system is in place. The Department believes that the ASC fee schedule as proposed is fair. The Department recognizes that the new Medicare system may provide a better structure for an ASC fee schedule. However, it cannot make the changes required upon adoption. The Department will, in future rulemaking, amend the ASC schedule and regulatory structure to make it consistent with the new system.

Comment: Several commenters also noted that the definition of ambulatory surgical case needs to be clarified, since in its present form it is too vague and will lead to litigation. One commenter recommended that the definition of ambulatory surgical case be amended to delete the reference to "minor surgery" and to permit all procedures, surgical and otherwise, to be performed in an ambulatory surgical center.

Response: The Department does not agree with the commenters. Since the Medicare list of procedures permitted to be performed in an ASC does not include some procedures commonly performed in such facilities on persons injured in automobile accidents, the Department chose not to limit the procedures that can be performed in an ASC except for minor surgical procedures. The Department believes it is appropriate to have a definition of “minor surgical procedures” that cannot be performed in ASCs to prevent unscrupulous providers from attempting to charge a facility fee for such services.

Comment: One commenter sought guidance on whether surgical procedures performed at an ASC that does not have an assigned group number will be reimbursable. The commenter further inquired whether CMS guidelines will be followed for acceptable ASC procedures.

Response: N.J.A.C. 11:3-29.4(o) makes it clear that the Department is not limiting the procedures performed in an ASC to those permitted by Medicare to be performed in an ASC. Procedures that do not have a group number on the physicians’ fee schedule but can be performed in an ASC should be placed in the group of the most similar type of procedure that is on the fee schedule. Concerning whether CMS guidelines will be followed for acceptable procedures, the Department is not sure to what the commenter is referring. The Department incorporated a number of provisions from the Medicare Claims Processing Manual for Ambulatory Surgical Centers into the proposal.

Comment: One commenter questioned whether ASCs that are certified by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) but are not certified by Medicare meet the definition of an ASC in the proposal.

Response: To be eligible to receive facility fees under PIP, an ASC must be licensed by the Department of Health and Senior Services or be a physician-owned single operating room certified by Medicare. These are the two forms of ASCs that are recognized under New Jersey regulations.

Comment: Several commenters recommended that ASC facilities include a copy of the invoice when billing for invoice plus 20 percent. One commenter inquired how a carrier/vendor should implement reimbursement.

Response: The Department agrees with the recommendation that ASCs should include the invoices when billing. Inclusion of the invoice will expedite the processing of the bill. The Department does not understand the commenter's question on how reimbursement should be implemented. As the Department's rules for billing by an ASC follow the Medicare rules, it should not be difficult to determine how they have been implemented by other payors. In addition, as noted above, the Department will propose amendments to assure that the regulatory structure remains consistent.

Comment: One commenter stated that the inclusion of virtually all services into the "facility fee" definition differs from the law, which allows for separate fees for supplies. The commenter suggested that the proposed definition will force patients to go to hospitals, which are already overcrowded.

Response: The Department is not aware of any law that requires that supplies be billed separately. The proposal followed Medicare rules in determining what is included in the facility fee. The Department believes that the proposal strikes an appropriate balance between what should be included in the facility fee and what can be billed separately. The Department is aware of some ASCs that bill separately for nearly every item used in a procedure in the ASC. This type of unbundling results in fees for procedures in ASCs that are much higher than those in hospitals and exerts upward pressure on PIP costs and, consequently, auto insurance rates.

Comment: Several commenters noted that the terms “surgeons” and “physician surgeons” should be revised to “plenary licensed physicians.” Absent this clarification, non-plenary licensed physicians working through an ASC might take the position that they are surgeons for purposes of billing and applying the fee schedule.

Response: The Department has concluded that such a change is unnecessary, as health care providers are required to work within their scope of practice and may not misrepresent to payors the nature of the services they provide.

Comment: One commenter objected to the reimbursement level for CPT Code 22505 compared to the customized fee analyzer prepared by Ingenix.

Response: The Ingenix fee analyzer service is based on billed fees. As noted above in response to other comments, the Department set the amounts on the physicians’ fee schedule based on a number of sources of paid fee information, including a database of fees actually paid by auto insurers.

Comment: Several commenters objected to the inclusion of powered traction therapy (VAX D or similar devices) into the fee for CPT 97026. These commenters believe that powered traction therapy is a different treatment even though it has not been given a separate CPT code.

Response: The Department does not agree with the commenters. As noted in the Summary to the Proposal, the Federal Food and Drug Administration’s (FDA) approval of VAX-D and other similar devices designate them as providing the modality of traction. Neither Medicare nor many other payors recognize decompression therapy and the Department is not aware of any rigorous independent scientific studies that show any greater benefit from the use of these devices than the modality of traction.

Comment: Several commenters noted that Certified Registered Nurse Anesthetists (CRNA) may also provide anesthesia, not just physicians. The proposal should clarify that payment for sedation by CRNA's is also bundled into payment for medical or surgical services. One commenter also suggested adding language to include the use of modifiers on anesthesia bills, as is done by Medicare, to identify who administered sedation.

Response: The Department agrees that the addition of provisions for CRNAs would be appropriate. However, the language suggested by the commenters would constitute a substantive change requiring additional notice and public comment. The Department will address this issue in future rulemaking. Until then, payors should do a UCR analysis to determine the appropriate reduction from the fee schedule amount for anesthesiologists for services provided by CRNAs.

Comment: One commenter asked about the survey mentioned in the Summary to the proposal that resulted in the fee for anesthesia services. The commenter stated that no information was provided as to who conducted the survey, how large it was, etc. The commenter believed that such data should be made public and be subject to comment before being included in the proposal.

Response: In the course of its informal conferences and consultations with interested parties about the content of a possible medical fee schedule, the Department discussed setting the fee for anesthesia services at 130 percent of the MPFS. Prior to the publication of the medical fee schedule rule proposal, representatives of the New Jersey State Society of Anesthesiologists met with the Department and provided information that the MPFS fee for anesthesia was much lower than other fees on the schedule. The Society provided information from members of the American Society of Anesthesiologists which was considered when the fee amount in the proposed rule was determined. This process, whereby interested parties were consulted on the fee schedule proposal, was used to

adjust many of the fees on the schedule. The opportunity for comment on the amounts in the fee schedule was provided by the proposal of this rule.

Comment: One commenter representing the New Jersey Speech Language Hearing Association recommended five additional codes for treatments related to their specialty be added to the fee schedule.

Response: The Department notes that codes that are not included on the fee schedule are reimbursed by the payor at UCR. The Department will determine whether the codes suggested by the commenter are performed frequently enough to merit being included on the schedule and, if so, include a proposal to do so in future rulemaking.

Comment: One commenter who owns an MRI facility stated that performing MRI studies for PIP patients resulted in additional costs for obtaining precertification, delays in payment and non-payment. In addition, MRI facilities are subject to additional licensing fees and NJ sales tax. The commenter stated that these additional costs amount to 35 to 40 percent of the current reimbursement for MRI's. The commenter claimed that the proposal reduced MRI fees by an average of \$100.00 and therefore, MRI providers would hesitate to take PIP claims.

Response: The Department does not agree with the provider that MRI fees have been reduced in the proposal. The fees for MRIs were set at a level consistent with that paid to most providers. The additional licensing fees and sales tax apply to all MRI services.

Comment: The Department received several comments from persons involved in medical transportation services. The commenters noted that the list of fees for ambulance services did not include the HCPCS code, A0429 BLS Emergency Transport.

Response: Upon review, the Department has determined that the omission of this code was an oversight. As was noted in the Summary of the proposal (38 N.J.R. 3440), it was the Department's intention to include all of Medicare's commonly used codes for ambulance services. The Department is amending the rule upon adoption to include this code.

Comment: Several commenters from medical transportation services asked why the Department was using 130 percent of Medicare for the physician fee schedule but only 100 percent of the Medicare fee schedule for ambulance fees and other non-physician services.

Response: As noted above in response to a previous comment, the Department is using the Medicare RVU system to rank the payments for various types of procedures. The amounts of the fees have been calculated from various sources as described in the Summary to the proposal and are expressed as a percentage of the MPFS. The fee schedules for the ambulance and durable medical equipment fee schedules have always been set at 100 percent of Medicare since Medical Transportation services generally accept Medicare reimbursement, and thus clearly meet the standard of fees accepted by 75 percent of providers of these services.

Comment: Several commenters representing medical transportation providers noted that there is an increasing need for municipal ambulance services to provide extraction services and requested that EMS providers be reimbursed for these services. The commenters suggested appropriate fee amounts for light, medium and heavy extraction.

Response: These comments are the first time that the Department has been made aware that extraction services are a separate service that is being billed by medical transportation providers. Adding fees for such services upon adoption would be a substantive change requiring additional notice and public comment. The Department will investigate whether fees for such services are

appropriate to be added to the ambulance fee schedule and, if so, what the fee should be and will consider addressing the issue in future rulemaking.

Comment: Several commenters sought clarification whether pre-certification guarantees prompt and full payment except in extraordinary cases. Several commenters noted that pre-cert only guarantees that there will be no retrospective review of medical necessity, once a treatment or supply has been precerted. Pre-cert is not a guarantee of payment since there are often questions of causality that impact on payment and sometimes there are situations in which codes deemed medically necessary by the carrier or vendor were not performed. Other commenters complained about the time it takes to get treatment requests precertified and stated that insurers or their vendors expect the provider to drop everything when they call to discuss treatment plans.

Response: While these comments are outside the scope of the proposal, as noted in the proposal summary, the Department is reviewing these issues separately.

Comment: One commenter stated that the proposed rule does not address the issue of repricing companies, third party administrators and other entities that are used by insurance companies to reduce payments to providers under the guise of reviewing the appropriateness of payments. The commenter stated that the Department has failed to look into the role these companies play and whether the savings they have effected have translated into cost reductions for insureds.

Response: While these comments are outside the scope of the proposal, as noted in the proposal summary, the Department is reviewing these issues separately.

Comment: One commenter stated that in the Summary to the rule the Department stated that it was currently examining information about insurers attempting to improperly deny, delay or reduce payment and is prepared to act in accordance with its findings. The commenter noted that there was nothing in the proposed rule that dealt with this issue in any meaningful way.

Response: While these comments are outside the scope of the proposal, as noted in the Summary, the Department is reviewing these issues separately.

Comment: One commenter noted that in the Summary to the proposal, the Department stated that precertification of treatment should guarantee prompt payment except in extraordinary circumstances where there is no coverage or evidence of fraud exists. The commenter found no mention of this in the body of the proposed rule itself, much less a mechanism to ensure that this policy of the Department would be workable and enforceable.

Response: The prompt payment of auto insurance claims is governed by statute at N.J.S.A. 39:6A-5g. The Department accepts complaints from providers alleging that insurers are not abiding by that statute or following the requirements of the Personal Injury Protection Benefits; Medical Protocols; Diagnostic Tests rule, N.J.A.C. 11:3-4.

Comment: One commenter stated that the proposed rule fails to recognize that the precertification procedure needs to be more flexible to cover procedures that are not precertified but are medically necessary to be performed during the course of the procedure. The commenter said that it is a common practice for insurance companies to refuse to pay or to place obstacles in the way of such additional procedures.

Response: The comment is outside the scope of the proposal. As noted in the Summary to the proposal, the Department is reviewing these issues separately.

Comment: One commenter noted that the proposal did not include any requirement for insurers to notify providers about the amounts of an insureds' remaining benefits and whether there were any pending claims that further limit or exhaust an insured's coverage. Another commenter noted that the proposal did not have any provisions for catastrophic claims where both the hospital and providers' bills can exceed the \$250,000 policy limit in a few days of treatment.

Response: The comments are outside the scope of the proposal, which deals with fee schedules, not rules for claim payments. The Department is considering rulemaking to address the situation involving catastrophic claims where there is a competition between the hospital and the attending physicians to claim the whole \$250,000 policy limit. Concerning exhaustion of benefits in non-catastrophic cases (such as where the insured has chosen lower PIP limits), the Department does not believe any regulation is necessary. The vast majority of other states have “med pay” or PIP limits that are much lower than New Jersey’s and providers in those states are able to deal appropriately with this issue on a regular basis. As noted in response to a previous comment, the Department is separately reviewing claim payment issues.

Comment: One commenter stated that his office has to send the office notes, examination findings and a treatment plan to the insurer or its vendor to request treatment and then is required to send the same information to the insurer with the bill to get paid. The commenter believes that the insurer’s precert department should send this information to the billing department. This commenter also stated that: the profits of insurance companies and the salaries and bonuses of executives should be made public; the salaries and bonuses of physicians employed by insurers, the number of hours worked per week and the percentage of their income derived from the insurance industry and that from private practice should be made public; 90 days is too long to process a claim for payment; that there should be a 30-day time limit to investigate a motor vehicle accident claim; the Independent Medical Exam (IME) physicians should disclose the income they received from IMEs, the length of time IME examinations take and the percentage of patients for which the IME physician authorizes continued treatment versus the percentage on which they recommend a termination of reimbursement for treatment; the number of arbitrations filed against insurance companies should be made public with a breakdown of who won and lost arbitration decisions, what was paid by the insurer to the physician

and to the physician's lawyer, how much money the insurer would have saved if it had paid the initial bill from the physician and that insurers that lose a lot of arbitrations should be fined; that the salary and retainer fees paid to a legislator or his or her firm that represents an insurance company should be disclosed, such salaries should be capped, it should be a conflict of interest for any legislator to vote for any legislation that favors the insurance industry or to be on any committee that votes on any legislation for the insurance industry.

Response: The comments are outside the scope of the proposal.

#### Federal Standards Statement

A Federal standards analysis is not required because the adopted medical fee schedules and rules are not subject to any Federal requirements or standards.

**Full text** of the adoption follows (additions to proposal indicated in boldface with asterisks **\*thus\***; deletions from proposal indicated in brackets with asterisks \*[thus]\*):

11:3-29.3      Regions

(a)      **\*The Regions in Appendix, Exhibit 1, Physicians' Fee Schedule, Exhibit 4, Ambulance Fee Schedule and Exhibit 7, Ambulatory Surgical Center Fee Schedule are as follows:\***

**\*1. South\*** Region \*[I, as used in this subchapter,]\* consists of Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Monmouth, Ocean and Salem counties, which are comprised of the following three- and five-digit zip codes in New Jersey: 077, 080, 081, 082, 083, 084, 086\*[,]\* **\*and\*** 087 \*[, 088 and 089]\*. **\*The South\*** Region \*[I]\* also includes: \*[08502, 08504, 08512, 08528, 08530, 08536, 08551, 08553,

08556 through 08559 and 08570]\* **08501, 08505, 08510, 08511, 08514 through 08527, 08533 through 08535, 08540 through 08550, 08554, 08555 and 08560 through 08562\***.

\*[(b)]\* **2. North**\* Region \*[II, as used in this subchapter,]\* consists of Bergen, Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic, Somerset, Sussex, Union and Warren counties, which are comprised of the following three- and five-digit zip codes in New Jersey: 070, 071, 072, 073, 074, 075, 076, 078\*.\* \*[and]\* 079\*, **088 and 089\***. **The North**\* Region \*[II]\* also includes: \*[08501, 08505, 08510, 08511, 08514, 08515, 08518, 08520, 08525 through 08527, 08533 through 08535, 08541 through 08544, 08550, 08554, 08555 and 08560 through 08562]\*\* **08502, 08504, 08512, 08528, 08530, 08536, 08551, 08553, 08556 through 08559 and 08570\***.

**\*(b) The Regions in Appendix, Exhibit 2, the Dental Fee Schedule are as follows:**

**1. Region I consists of the following three-digit zip codes in New Jersey: 080,**

**081, 082, 083 and 084.**

**2. Region II consists of the following three-digit zip codes in New Jersey: 077,**

**078, 079, 085, 086, 087, 088 and 089; and**

**3. Region III consists of the following three-digit zip codes in New Jersey:**

**070, 071, 072, 073, 074, 075 and 076.\***

11:3-29.4 Application of medical fee schedules

(a) Every policy of automobile insurance and motor bus insurance issued in this State shall provide that the automobile insurer's limit of liability for medically necessary expenses payable under PIP coverage, and the motor bus insurer's limit of liability for medically necessary expenses payable under medical expense benefits coverage, is the fee set forth in this subchapter. Nothing in this subchapter shall, however, compel the PIP insurer or a motor bus insurer to pay more for any service

or equipment than the usual, customary and reasonable fee, even if such fee is well below the automobile insurer's or motor bus insurer's limit of liability as set forth in the fee schedules. The physicians' fee schedule at subchapter Appendix, Exhibit 1 shall not apply to \*[services provided in the trauma units]\* **trauma services**\* at Level I and Level II trauma hospitals. **Trauma services means the care provided to patients whose arrival requires trauma center activation or whose care requires the consultation or services of trauma service physicians.**\* \*[Services]\* **Bills for services**\* subject to the **trauma services**\* exemption \*[for trauma units]\* shall use the modifier \*["-TU"]\* **-TS**\*. Surgical services (CPT 10000 through 69999) provided in emergency care in acute care hospitals that are not subject to the trauma care exemption shall be reimbursed at 150 percent of the physician's fee schedule and shall use the modifier "-ER". Insurers are not required to pay for services or equipment that are not medically necessary.

(b) – (d) (No change from proposal.)

(e) Except as noted in (e)1 and 2 below, the insurer's limit of liability for any medical expense benefit for any service or equipment not set forth in or not covered by the fee schedules shall be a reasonable amount considering the fee schedule amount for similar services or equipment in the region where the service or equipment was provided or, in the case of elective services or equipment provided outside the State, the region in which the insured resides. Where the fee schedule does not contain a reference to similar services or equipment as set forth in the preceding sentence, the insurer's limit of liability for any medical expense benefit for any service or equipment not set forth in the fee schedules shall not exceed the usual, customary and reasonable fee.

1. For the purposes of this subchapter, determination of the usual, reasonable and customary fee means that the provider submits to the insurer his or her usual and customary fee\*[ , that is, the amount that the provider is reimbursed for the service by all payors]\*. The insurer determines

the reasonableness of the provider's fee by comparison of its experience with that provider and with other providers in the region. The insurer may use national databases of fees, such as those published by Ingenix ([www.ingenixonline.com](http://www.ingenixonline.com)) or Wasserman (<http://www.medfees.com/>), for example, to determine the reasonableness of fees for the provider's geographic region or zip code.

2. (No change from proposal.)

(f) The following shall apply to multiple and bilateral surgeries (CPT 10000 through 69999), co-surgeries and assistant surgeons:

1. For multiple surgeries, rank the surgical procedures in descending order by the fee **\*amount, using the fee\*** schedule **\*or UCR amount, as appropriate\***. The highest valued procedure is reimbursed at 100 percent of the eligible charge. Additional procedures are reported with the modifier "-51" and are reimbursed at 50 percent of the eligible charge. If any of the multiple surgeries are bilateral surgeries using the modifier "-50," consider the bilateral procedure at 150 percent as one payment amount, rank this with the remaining procedures, and apply the appropriate multiple surgery reductions.

2 – 7 (No change from proposal.)

(g) Artificially separating or partitioning what is inherently one total procedure into subparts that are integral to the whole for the purpose of increasing medical fees is prohibited. Such practice is commonly referred to as "unbundling" or "fragmented" billing. Providers and payors shall use the National Correct Coding Initiative Edits, incorporated herein by referenced, as updated quarterly by CMS and available at [\\*\[http://www.cms.hhs.gov/physicians/cciedits/\]\\*](http://www.cms.hhs.gov/physicians/cciedits/) **\*http://www.cms.hhs.gov/NationalCorrectCodInitEd/\***.

1 – 6 (No change in text.)

(h) To be reimbursable, nerve conduction studies (NCS) (CPT 95900 - 95904) must be

interpreted by a \*[physician]\* \***provider**\* who was on site and directly supervised or performed the nerve conduction study **\*in accordance with N.J.A.C. 13:35-2.6(n)3\***. Needle \*

**\*Electromyography\*** **(\*EMG\*)** interpretation must be performed in the same facility on the same day by the same physician who performed and/or supervised the \*[nerve conduction studies]\* \***needle EMG**\*.

(i) - (j) (No change from proposal.)

(k) CPT codes for \*[unlisted]\* procedures \*[or services that are not on the fee schedule]\* **\*described in CPT as “unlisted procedure” or “unlisted service”\*** (example: #64999 Unlisted procedure nervous system) are not reimbursable without documentation from the provider describing the procedure or service performed, demonstrating its medical appropriateness and indicating why it is not duplicative of a code for a listed procedure or service. Documentation may include the existence of temporary or AMA Category III or HCPCS codes for the procedure or information in the AMA CPT Assistant publication. In submitting bills for unlisted codes, the provider should base the fee on a comparable procedure. It is never appropriate for the provider to bill an unlisted code for a list of services that have CPT codes. Providers that intend to use unlisted codes in non-emergency situations are encouraged to notify the insurer in advance through the precertification process. Based on the information submitted by the provider, the insurer shall determine whether the CPT coding is appropriate.

(l) – (n) (No change from proposal.)

(o) ASC facility fee group numbers are indicated by CPT code on the physician’s fee schedule, subchapter Appendix, Exhibit 1. The facility fees for each ASC group are listed in subchapter Appendix, Exhibit 7. If a procedure can be performed in an ASC but it is not listed in the physician’s fee schedule, the ASC facility fee for the procedure shall be the fee group in Appendix,

Exhibit 7 that includes procedures similar to the unlisted procedure. For example, if an injection code is not included in Appendix Exhibit 7, the facility fee for the procedure would be the same as for other injection codes that have a group number. In no case, shall a facility fee be greater than the highest facility fee on the schedule (Group 9). If a CPT code is subsequently assigned an ASC group number by Medicare, as found in [\\*\[http://www.cms.hhs.gov/providers/pufdownload/default.asp#asc\]\\*](http://www.cms.hhs.gov/providers/pufdownload/default.asp#asc) [\*\*\\*http://www.cms.hhs.gov/ascpayment/\\*\*\*](http://www.cms.hhs.gov/ascpayment/), the facility fee for that code shall be that of the same group number in Appendix, Exhibit 7. The ASC facility fee includes services that would be covered if the service were furnished in a hospital on an inpatient or outpatient basis, including:

1. - 7. (No change from proposal.)
- (p) (No change from proposal.)

## Exhibit 4

## Ambulance Services

<u>HCPCS</u>	<u>Description</u>	<u>North</u>	<u>South</u>
...			
A0428	AMBULANCE SERVICE BLS, NON-EMERGENCY TRANSPORT	222.41	208.78
<b>*<u>A0429</u>*</b>	<b>*<u>AMBULANCE SERVICE,</u></b> <b><u>BLS, EMERGENCY</u></b> <b><u>TRANSPORT*</u></b>	<b>*<u>355.85</u>*</b>	<b>*<u>334.05</u>*</b>
A0431	AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT ONE WAY (ROTARY WING)	3,264.60	3,116.07
...			