

INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

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

Adopted New Rule: N.J.A.C. 11:3-29 Appendix, Exhibit 6
Adopted Amendments: N.J.A.C. 11:3-29.2, 29.4 and 11:3-29 Appendix, Exhibit 3
Proposed: March 18, 2002 at 34 N.J.R. 1237(a)
Adopted: March 11, 2003 by Holly C. Bakke, Commissioner, Department of Banking
and Insurance
Filed: March 12, 2003 as R.2003 d. 143, with a technical change not requiring
additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 39:6A-4.6
Effective Date: April 7, 2003
Expiration Date: January 4, 2006
Summary of Public Comments and Agency Responses:

The Department of Banking and Insurance ("Department") received timely written comments from:

Deborah A. Wean, New Jersey Manufacturers Insurance Group;
Kevin J. Curry, First Trenton Indemnity Company;
Charles D. Vogel, Esq., State Farm Indemnity Company;
Alma L. Saravia, Esq., Flaster Greenberg, P.C.;
David Simon, D.C.;
Michael P. Garry, D.C., Bridgewater Chiropractic Associates;
D.D. Humber, D.C., International Chiropractors Association;
Michael W. Goione, D.C., Monmouth/Ocean County Chiropractic Society;
Yolanda L. Doss, American Osteopathic Association;
Walter R. Bliss, Jr., Esq., Alliance of American Insurers;
Garrick J. Stoldt, Clara Maass Medical Center;
Monica Gonzalez, D.C.;
Sally Kneipp, Ph.D., Counseling and Rehabilitation of New Jersey;
Patrick Ahearn, St. Barnabas Medical Center;
Dean Insana, D.C., Cherry Hill Wellness Center;
Kevin D. Pleasant, Irvington General Hospital;
Barry Coniglio, D.C., Southern New Jersey Chiropractic Society;
Ronald F. Saltiel;
Barbara Salandria, National Health Care Resources, Inc.;
Theresa M. Cologie, St. Barnabas Behavioral Health Center;
Sharon M. Guida, R.N., D.C., Central New Jersey Chiropractic Society;
Gary S. Carter, New Jersey Hospital Association;

Michael Stadafino, D.C., New Jersey Chiropractic Society;
Joseph Vescio, St. Clare's Hospital;
John K. Tiene, Insurance Council of New Jersey;
Robert B. Sica, Ph.D., Neuropsychology Rehabilitation Services;
Diana T. McCormick, Southern Ocean County Hospital;
Angie Rush, Consolidated Services Group, Inc.;
Peggy Stavitz, St. Barnabas Health Care System;
Roseann Tambone, East Orange General Hospital;
Veronica D'A Zeichner, Newark Beth Israel Medical Center;
W. Brian Atkisson, D.C., New Jersey State Board of Chiropractic Examiners;
Richard Santucci, D.C., Bergen Family Chiropractic Center;
Patricia S. Jackson, American Chiropractic Association;
Richard L. Stoneking, American Physical Therapy Association of New Jersey;
Donald C. DeFabio, D.C., DeFabio Chiropractic Offices;
Richard R. Guma, D.C.;
Thomas K. Charles, Morris Area Rehabilitation Association, Inc.;
Dean Curtis, D.C.;
Joy Weisbecker and Gail Halcomb, ALTA Services; and
Keith D. Cicerone, Ph.D., J.F.K. Johnson Rehabilitation Institute Center for Head Injuries

COMMENT: One commenter appreciates the proposed amendments and the intent of the Department to address some of the problems that are the result of the rules' implementation. Several commenters commended the Department on its efforts to clarify the provisions pertaining to the \$90.00 per day cap on physical and rehabilitative therapy. Another commenter stated that the creation of Appendix, Exhibit 6 will assist in preventing confusion regarding the codes subject to the daily maximum of \$90.00. One commenter supported the \$90.00 daily maximum cap as an important part of the cost controls of the medical fee schedule. Another commenter recommended that the specific language concerning the application of medical fee schedules at N.J.A.C. 11:3-29.4 be clarified so that it is more readily apparent that codes other than those listed in Appendix 6 are not subject to the daily maximum.

RESPONSE: The Department appreciates the support. The Department believes that the rule is sufficiently clear as to what codes are subject to the daily maximum.

COMMENT: Several commenters submitted similar letters expressing support for the addition of a fee for medical social workers.

RESPONSE: The Department appreciates the support.

COMMENT: Several commenters wrote to express support for the proposal that will allow patients with severe injuries to multiple body parts to receive appropriate care, as additional reimbursement will be forthcoming when a provider is treating more severe injuries.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter concurred with the Department's proposed amendments to N.J.A.C. 11:3-29.4(i) requiring a provider utilizing a CPT billing code for an unlisted procedure or service to submit documentation describing the procedure or service performed, demonstrating its medical appropriateness, and indicating why it is not duplicative of a listed code. The commenter noted that such documentation should enable insurers to more efficiently process claims since information necessary for proper claims evaluation will now initially be submitted by providers in every instance that an unlisted procedure service code is used. The commenter noted that such documentation might enable insurers to more readily determine whether claims have been inappropriately bundled or whether a CPT code contained in the fee schedule can instead be utilized.

RESPONSE: The Department appreciates the support.

COMMENT: Several commenters noted that the physical therapy evaluation and reevaluation codes (97001-97002) do not represent treatment but establish the physical status of the patient and treatment required. Therefore, it is appropriate to remove these from the daily maximum cap. One commenter believes that the amendment proposed at N.J.A.C. 11:3-29.4 will cause insurance carriers to recognize physical therapy evaluation and reevaluation services separately from the other services commonly provided together and reimburse accordingly. The commenter further stated that a text clarification that would specify that physical therapists are to be reimbursed for evaluation and reevaluation services in addition to the \$90.00 daily cap would be appreciated.

RESPONSE: The Department appreciates the commenter's recognition of the appropriateness of the removal of the physical therapy evaluation and reevaluation codes from the daily maximum cap. The fact that the codes subject to the \$90.00 daily maximum have been listed specifically and that the physical therapy and reevaluation codes have been removed should be sufficient to indicate that they should be reimbursed separately if determined to be medically necessary.

COMMENT: Several commenters supported the proposed rate increase for home health care. One commenter noted that the rates have not increased since 1991, when the fee schedule was originally created, and that they are appropriate and timely. One commenter believes that home health care is an important adjunct to patient recovery and that it is necessary for home health care workers to receive competitive wages to insure that there are adequate resources available. One commenter stated that the increases in the home care service fee schedule are appropriate and timely.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter noted that, in response to concerns that home based physical therapy services have historically been underpaid, the Department is now proposing that the fees paid be increased from \$77.00 to \$90.00. The commenter believes that by doing so, there will be parity among all outpatient and home health rehabilitation providers. The commenter also suggested that in the future, the fee schedule should be revisited annually to make adjustments for inflation and cost of living.

RESPONSE: The Department appreciates the support. N.J.S.A. 39:6A-4.6 requires that the fee schedules be adjusted biennially to account for inflation and the addition of new procedures.

COMMENT: One commenter commended the Department for acknowledging problems in the medical fee schedule and stated that the amendment fairly compensates quality health care providers and penalizes those who might overutilize or commit fraud.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter was in favor of the proposal. The commenter stated that the codes listed in Appendix 6 are typical services provided together and that services not listed in Appendix 6 are typical of extraordinary treatment and tests associated with more severe injury types that require additional reimbursement and the amendments will provide the therapy necessary to treat more severe injuries.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter applauded the expanded explanation of services that would warrant payment over the \$90.00 daily cap. The commenter stated that it has seen many instances of billings where the provider has stated that additional payments are due because there was treatment to different body parts but no severe or catastrophic injuries were present. The commenter stated that the use of the -22 modifier would be helpful in identifying extraordinary services rendered in cases of such severe injuries. The commenter also suggested that the section include a stipulation that the insurer must agree that the services warranted additional payment. Otherwise, many providers may assume that use of the modifier automatically entitles them to additional payment.

RESPONSE: The Department appreciates the support. As with any treatment, the payor must agree that the services were actually provided and are medically necessary before making payments to a provider. The rule provides a general discussion of the types of injuries that may necessitate additional treatment. A provider should not assume that simply adding the -22 modifier to a CPT code entitles him or her to the additional reimbursement unless the bill was accompanied by an explanation of why the additional treatment is warranted.

COMMENT: One commenter suggested that the \$90.00 per day cap on physical and rehabilitative therapy services set forth in Appendix 6 should also include CPT Codes

97780 and 97781. The commenter stated that these codes are for acupuncture and were previously included in the cap and are provided as a component of rehabilitation treatment in conjunction with other rehabilitation codes. Another commenter stated that there is confusion about acupuncture and whether the \$90.00 daily cap applies to it. The commenter believes that acupuncture is a physical medicine procedure similar to other modalities included in the cap and that the cap should apply to this service.

RESPONSE: The Department does not agree with the commenters. The basis for inclusion of services in the daily maximum is that that they are commonly provided together. While acupuncture may be a component of rehabilitation treatment, at this time the Department has no evidence that it is commonly provided together with the other rehabilitation codes that are subject to the daily maximum. Any confusion about what codes are included in the daily maximum has been resolved by the adoption of Appendix, Exhibit 6, which lists the specific codes that are subject to the maximum. No acupuncture codes are included in this list.

COMMENT: One commenter disagreed with the Department's decision to remove Physical Medicine and Rehabilitation ("P M and R") CPT codes from the \$90.00 daily cap without also including all P M and R CPT codes in the fee schedule and placing limitations on the frequency with which such codes can be billed. By removing the \$90.00 cap for P M and R CPT codes appearing in the fee schedule, insurers cannot easily dispute abuses by providers for billing too frequently for such procedures or services.

RESPONSE: As noted above in response to another comment, the basis for inclusion of services in the daily maximum is that that they are commonly provided together, not that providers bill too frequently or too much for such services. The Department is planning to propose amendments to the fee schedule that will include additional codes. Overutilization of a treatment is addressed in the decision point and precertification requirements, N.J.A.C. 11:3-4.

COMMENT: One commenter stated that codes 97112 (Balance Coordination Training), 97116 (Gait Training), 97530 (Therapeutic Activities), 97039 (Unlisted Procedure), 97130 (Unlisted Therapeutic Procedure), and 97535 (Activities of Daily Living - Self-Care Instructions) should be included in the \$90.00 per day cap on physical and rehabilitative therapy as they are services regularly listed on bills for physical therapy visits. The commenter stated that inclusion of these codes in the cap would help prevent potential billing abuses for these treatments and procedures. Another commenter suggested that other CPT codes be added to Appendix, Exhibit 6 so that they will be subject to the \$90.00 daily cap. The codes suggested for inclusion are: 97112 Therapeutic Procedure (balance coordination); 97113 Therapeutic Procedure (aquatic therapy); 97116 Therapeutic Procedure (gait training); 97139 Unlisted Therapeutic Procedure; 97530 Therapeutic Activities Direct PT Contact; 97545 Work Hardening; 97750 Physical Performance Test/Measure with report each 15 minutes; 97780 Acupuncture without Electrical Stimulus and 97781 Acupuncture with Electrical

Stimulus. As an alternative, the commenter suggested setting forth the above-referenced codes elsewhere in the Appendix and establishing a daily cap for them ranging from \$90.00 to \$125.00. Another commenter agreed with the removal of 13 CPT codes from those subject to the \$90.00 per day maximum daily allowance. The codes identified by the commenter were 97001, 97002, 97003, 97004, 97116, 97504, 97520, 97535, 97537, 97542, 97545, 97546 and 97703. The commenter stated that all the other physical medicine and rehabilitation codes proposed to be removed from the \$90.00 per day cap should continue to be subject to that cap. Another commenter noted that CPT codes 97110, 97124, 97140 and 97150 relate to exercises and mobilization and are proposed to be included in the \$90.00 per day maximum cap. The commenter believes that physical medicine codes 97112, 97113, 97116, 97530 and 97542 describe similar therapies that are provided together and therefore should be included in the \$90.00 maximum cap.

RESPONSE: The changes requested by the commenters cannot be made upon adoption since they require additional notice and public comment. The Department will review whether the additional CPT codes are services that are commonly provided together and, therefore, should be included in the daily maximum.

COMMENT: One commenter noted that Appendix Exhibit 6 does not include code 98943 (extra-spinal manipulation) and therefore it is not included in the daily cap. It would appear that excluding this code from the daily cap insinuates that extra-spinal manipulation is not routine, and is performed only in the most exceptional cases when there is serious traumatic injury. The commenter stated that although it is performed much less frequently than spinal manipulation, it is arguably not performed in only the most exceptional cases. The exclusion of code 98943 from the \$90.00 daily cap could inadvertently encourage unscrupulous providers to overutilize this service in order to exceed the cap on a routine basis.

RESPONSE: The Department does not agree with the commenter that the exclusion of CPT 98943 (extra-spinal manipulation) from the daily maximum means that it is performed only in the most exceptional cases. As noted above in response to an earlier comment, the daily maximum implements the statutory authorization to establish a single fee for services commonly provided together. The Department has determined that CPT 98943 is not commonly provided with other services and therefore should not be included in the daily maximum. The daily maximum does not replace the ability of insurers to determine what treatments are medically necessary.

COMMENT: One commenter stated that after the recent revision to the fee schedule eliminating payment for administration of hot and cold packs, there has been an increased use of CPT Code 97026 (infrared heat source) for the same purpose as a hot pack to enable providers to obtain reimbursement. The commenter noted that this is an area that the Department has already visited, and is concerned because it is subject to abuse. The commenter suggested that all cold and heat therapies be included in the fee schedule with a value of zero.

RESPONSE: The commenter's suggestion is beyond the scope of the proposed rulemaking. The Department invites interested parties to submit information on whether CPT 97026 is being abused. Information on this matter should be sent to Assistant Commissioner Jean Bickal, P.O. Box 325, Trenton, NJ 08625 (jbickal@dobi.state.nj.us).

COMMENT: One commenter stated that considering the exorbitant rates charged by New Jersey automobile insurance companies, the PIP reimbursement rates are extremely low and not competitive. The commenter stated that the medical community is expected to bear the expense of providing care for insureds. One commenter stated that there should be no caps on visits but rather approval for services on a weekly basis.

RESPONSE: The Department does not agree with the commenter's characterizations of PIP premiums and reimbursement rates. Further, the comment is outside the scope of the proposal.

COMMENT: One commenter requested that the Department clarify N.J.A.C. 11:3-29.4(c). It appears that the insurer is liable for only 15 months' rental of an item of durable medical equipment. Since some patients who are severely injured require years of treatment, this time limitation could compromise care.

RESPONSE: The comment is outside the scope of the proposal since N.J.A.C. 11:3-29.4(c)2 was not proposed for amendment. However, the purpose of the limitation on the rental of durable medical equipment is to prevent an insurer paying more for a long-term rental than the equipment would cost if purchased.

COMMENT: One commenter recommended that consideration be given to excluding certain conditions from the \$90.00 daily maximum by ICD diagnostic code. The commenter went on to recommend that ICD-9 codes 800 through 804 and 850 through 854 for catastrophic traumatic brain injury, ICD-9 codes 805 – 806 covering non-soft tissue injuries – spinal cord injuries and CPT codes 430 through 438 – stroke, be excluded from the daily maximum.

RESPONSE: The change requested by the commenters cannot be made upon adoption since they require additional notice and public comment. The Department believes that it is more appropriate to base exemptions from the cap on the treatment required by the injuries rather than a specific diagnosis. However, the Department will monitor use of the exemption and make changes in future rulemaking if necessary.

COMMENT: One commenter stated that handling of provider bills for treatment in Level I and Level II trauma centers needs clarification. The commenter stated that providers take the position that all services or procedures performed on patients who enter the facility through the emergency room are excluded from the fee schedule even after they have stabilized and left the emergency room. The commenter suggested that the rule should be amended so that provider services are subject to the fee schedule after the

patient leaves the emergency room, or that codes should be added listing the amounts of maximum payment for emergency and non-emergency room services rendered at Level I and Level II trauma centers.

RESPONSE: The comment is outside the scope of the proposed rulemaking. The Department will consider the suggestion for future rulemaking.

COMMENT: One commenter noted that if the rule removes any services from the daily maximum allowance, it should also clarify whether the multiple fee schedule reduction formula applies.

RESPONSE: The Department does not agree with the commenter. N.J.A.C. 11:3-29.4(f) states clearly that except for codes subject to the daily maximum, the multiple procedures reduction formula applies.

COMMENT: One commenter was concerned about the removal of CPT codes 97039 and 97139 (unlisted procedure and unlisted therapeutic procedure) from Appendix Exhibit 6, which the commenter believes would then result in these procedures not being subject to the \$90.00 a day daily maximum fee. Another commenter noted that if the daily maximum does not include unlisted procedure or service codes in Exhibit 6, providers are motivated to use such codes as they remove the procedure or service from the fee schedule and the application of the \$90.00 daily cap. Another commenter stated that removing the “unlisted procedure” codes from the \$90.00 daily maximum creates a problem. The commenter noted that although providers are required to describe services represented by these codes, the fee schedule does not establish a dollar value for the services and these services would have to be reimbursed at the level of their usual, customary and reasonable charge. Since these codes can be used to describe a variety of services, it would not be possible to establish a usual, customary and reasonable charge, and the ultimate result will be that providers will be reimbursed based on their submitted charges. Another commentor noted that the CPT manual provides codes for treatments that are considered standard for physical therapy and that if the treatment is not represented by the CPT manual, there is a question whether the treatment has undergone the rigorous testing and physician review required to establish its therapeutic value and standard for use. The commenter also noted that proposed N.J.A.C. 11:3-29.4(i) states that the unlisted codes will not be reimbursed without documentation describing the procedure or service and the medical necessity. The commenter stated that precertification should catch the majority of these codes at the time of treatment request and that these codes will then be evaluated. If the provider bills for treatment using codes that were not approved, then these bills should be denied. However, if an insured does not use the precertification mechanism or a provider does not submit for approval, then these codes can be used by the provider to maximize reimbursement. The commenter noted that submitted documentation often does not adequately support the medical necessity or appropriateness, but the insurer pays the provider in order to avoid going to arbitration. The commenter further stated that health insurers and Medicare do not pay for treatment that does not have an

established set of criteria for use and that Medicare has an established fee schedule for 97039 and 97139, but does not pay for 97799.

RESPONSE: As noted above in response to an earlier comment, the daily maximum is intended to cover services normally provided together. The daily maximum is not intended to provide a substitute for the obligation of insurers to reimburse the usual, reasonable and customary fee for a service. The Department does not believe that an "unlisted procedure", that is, one that is so uncommonly performed that it does not have a CPT code, would be "commonly provided" with the other codes subject to the daily maximum. N.J.A.C. 11:3-29.4(i) requires that any bill for an unlisted code be accompanied by an explanation of the procedure performed and why it is not covered by an existing CPT code. This should prevent the use of such codes to avoid the daily maximum.

COMMENT: The commenter was concerned with those patients whose level of treatment will exceed the \$90.00 cap. The commenter asked what will happen to the patient whose injuries require not only treatment, but a rehabilitation and exercise program to help restore normal function, or to the patient that, due to his or her significant injuries, requires greater levels of treatment.

RESPONSE: The insurer has the ability to waive the cap where the provider demonstrates that additional treatment is necessary over the \$90.00 daily maximum.

COMMENT: One commenter noted that there appears to be a typographical error in N.J.A.C. 11:3-29.4. The commenter believes the sentence should read, "Unless already provided to the insurer as part of a decision point review or precertification request, the billing shall be accompanied by documentation of why the extraordinary time and effort for treatment was needed."

RESPONSE: The Department agrees with the commenter that there was a typographical error in the rule and is making the correction upon adoption.

COMMENT: One commenter suggested that the rule at N.J.A.C. 11:3-29.4 "regarding equipment purchases" should provide that the amounts paid by an insurer for purchased equipment not listed in the fee schedule should be limited to a percentage above the provider's purchase invoice for that equipment. The commenter noted that with rapidly changing technology, the issue of what is an appropriate payment is complicated and has resulted in disparate payment among insurers.

RESPONSE: The comment is outside the scope of the proposed rulemaking. The Department will consider the suggestion for future rulemaking.

COMMENT: One commenter criticized the requirement that a provider use modifier -22 "unusual procedural services" when the service provided is greater than that usually required for the listed procedure. The commenter stated that using the 15-minute unit

(X8) is the standard and traditional neuropsychological rehabilitation (cognitive therapy). However, people in the field today have adulterated this formula due to poor training and professional ignorance. The commenter believes this modifier should not be applicable to cognitive therapy in view of its long-standing and appropriate usage over the years. The commenter suggested that those providing cognitive therapy should be paid at what is considered usual and customary or that a fee needs to be established for this code as reasonable to all parties.

RESPONSE: The commenter has misunderstood the proposal. The modifier -22 for "unusual procedural services" is to be used when a provider is seeking to have the \$90.00 daily maximum waived. Cognitive therapy has been removed from the CPT codes that are subject to the daily maximum.

COMMENT: One commenter noted that only one code, 98924, is included in the medical fee schedule for osteopathic manipulative technique and that the fee schedule amount for that code is \$39.85. The commenter requested that codes 98926 through 98929 be added to the fee schedule. The commenter noted that, at the current time, if a physician applies OMT on more than two body regions, he or she is compensated the same amount as if OMT was performed on one or two regions of the body. In view of the modest fee set for code 98925, a physician cannot afford to treat a patient for the longer period of time it takes to treat several body regions if he or she is not receiving equitable compensation for the procedure.

RESPONSE: The comment is outside the scope of the proposed rulemaking. The Department will consider the suggestion for future rulemaking.

COMMENT: One commenter recommended that fee schedules be clarified or that additional fee schedules be developed. The commenter stated that the lack of fee schedule codes for facility charges and services and procedures performed in ambulatory surgical centers has become an area of dispute. The commenter stated that bills from these types of centers have fees far in excess of what is billed for the same service provided in an acute care hospital. The commenter therefore suggested a separate fee schedule for facility charges and services rendered in ambulatory surgical centers or inclusion in the existing fee schedule of specified fees for ambulatory surgical center facility charges and services.

RESPONSE: The comment is outside the scope of the proposed rulemaking. The Department will consider the suggestion for future rulemaking.

COMMENT: One commenter was concerned about CPT codes 97003 and 97004 being omitted from Appendix Exhibit 6. The commenter requested the Department to identify a fee schedule amount for these codes and the frequency and conditions under which they can be billed. One commenter stated that if CPT codes 97780 and 97781 for acupuncture are not to be included in the \$90.00 daily maximum fee, then a fee schedule amount should be assigned to those codes to avoid confusion. One

commenter stated that the occupational therapy evaluation and reevaluation codes (97003-97004) are proposed to be excluded from the daily maximum cap, but are not listed on the fee schedule. These codes are used when cognitive or physical status requires assessment in order to determine treatment or therapy. It is appropriate to remove these codes from the daily maximum cap; however, a fee schedule rate needs to be established.

RESPONSE: The comments are outside the scope of the proposed rulemaking. The Department is in the process of preparing revisions to the fee schedule that will include additional CPT codes.

COMMENT: One commenter stated that CPT codes contained in the fee schedule relating to surgical procedures should be expanded because currently there are only 92 codes for surgical procedures whereas many more surgical procedures are frequently performed. The commenter stated that adding codes to the fee schedule will avoid disputes between insurers and providers as to what are usual, customary and reasonable fees.

RESPONSE: The comment is outside the scope of the proposed rulemaking. The Department is in the process of preparing revisions to the fee schedule that will include additional CPT codes.

COMMENT: One commenter suggested that CPT codes A6263, B4034-4036, E0745, All J Codes, All K codes, L0984, A4455, B4150-B4256, E0747, L-0690, A4556, B4086, E0749, L3000-L3223, A4457, B9000, E0830, L-3225-L3649, A4245, B9002, E1221, A4565, B4083, E1300, A4570, E0625, A4927, E0720, A5119, E0730, A4215, E0130, A4208, E0144, A616, E0148, A4335, E0149A5112, E0159, A6234-A6239, E0162, A4554, E0169, A4615, E0188, A4617, E0189, A6216-A6406, E0241-E0246, E0270, E0273, E0274, E0425, E0430, E0435, E0440 and E0179 should be added to the fee schedule for equipment since the codes listed represent equipment frequently purchased or rented for the benefit of a PIP claimant.

RESPONSE: The comment is outside the scope of the proposed rulemaking. The Department is in the process of preparing revisions to the fee schedule that will include additional CPT codes.

COMMENT: One commenter stated that code 97542 does not have a fee schedule rate assigned to it and if the code is to remain outside the daily maximum cap, it should be assigned a rate.

RESPONSE: The comment is outside the scope of the proposed rulemaking. The Department is in the process of preparing revisions to the fee schedule that will include additional CPT codes.

COMMENT: One commenter was extremely troubled by the proposal and urged the Department to reconsider the proposal to add five codes for Osteopathic Manipulative

Treatment to the \$90.00 daily cap; with the exception that if Osteopathic Manipulative Treatment (hereinafter “OMT”) is performed by a physician, then it should not be subject to the cap. The commenter stated that the change makes no sense as it is a violation of the CPT code for anyone other a physician to perform OMT and contrary to the American Osteopathic Association’s position paper. Another commenter was concerned that if the proposal is adopted, osteopathic physicians who conduct OMT will be forced into the \$90.00 a day cap by insurers who misapply the regulation.

RESPONSE: The commenters have misunderstood the proposal. Codes for Osteopathic Manipulative Treatment have not been added to the daily maximum; they were already subject to the maximum. Appendix, Exhibit 6 added a list of the codes that are subject to the maximum rather than referring to a section of the CPT book.

COMMENT: One commenter noted that osteopathic physicians represent five percent of the physician population in the United States. The commenter also noted that osteopathic physicians are fully licensed physicians and surgeons who stress the unity of all body systems. The commenter noted OTM is a distinct medical procedure provided by osteopaths. The CPT 2001 lists five codes for OTM. The number of body regions manipulated determines which code will be reported. The commenter concluded that OTM codes should be excluded from the list of physical medicine and rehabilitation CPT codes that are subject to the daily maximum and that excluding the OTM codes (98925 - 98929) would support the previous distinctions that have been acknowledged by the CPT since its inception.

RESPONSE: The comment is outside the scope of the proposal since, as noted above in response to an earlier comment, the proposal did not add or delete any OMT codes from those subject to the cap.

COMMENT: One commenter noted that chiropractors are considered physicians in the State of New Jersey; that they are primary care providers who do not require referral from another provider to treat a patient; and that they are responsible for rendering a diagnosis and laying out a course of treatment for a patient. However, the Department has chosen to include chiropractors with physical therapists for purposes of reimbursement levels. The commenter noted that physical therapists are not primary care providers and are dependent upon referrals and guidance from physicians, including chiropractors. This treatment points out the inconsistencies and potential illegalities contained in the fee schedule.

RESPONSE: The Department does not agree with the commenter. The basis for inclusion of services in the daily maximum is that that they are commonly provided together not because one type of provider is a primary care provider and another is not.

COMMENT Several commenters expressed very strong objections and opposition to the amendment to the fee schedule regarding the \$90.00 a day cap. Some commenters believed the amendment to be unlawful, discriminatory and demeaning to the chiropractic profession because it exempts only medical doctors and osteopaths

from the \$90.00 a day cap. One commenter stated that the rule ignores and fails adequately to address the basis for singling out chiropractors as the only primary health care provider subject to the \$90.00 a day cap. Several commenters questioned why manipulation by an osteopath or medical doctor is not subject to the same limitations as manipulation by a chiropractor, when all are primary care providers. Several commenters stated that the chiropractic profession is the most highly trained group of health care professionals who perform any type of manipulation. One commenter stated that either all manipulative therapies should be included in the \$90.00 a day cap or all manipulative therapies should be outside the cap. Several commenters stated that the rule creates a two-tiered system for treatment of patients undergoing physical medicine procedures and would have a negative social impact by creating a discriminatory atmosphere between different professions and establish a class system within the health care profession. The commenters averred that the amendments would foster antagonism between various health care providers within the State, which would not be in the best interest of the consumer and that segregation and discrimination of professionals is unacceptable and cannot be tolerated. Chiropractors are limited in their charges, but osteopaths and medical doctors, who have far less manipulative training, can charge the unlimited fee plus get additional reimbursement for what is in effect the same treatment. One commenter stated that CPT codes that have been identified in the proposed regulation target the chiropractic profession; that codes primarily used by doctors of chiropractic are capped; and that this inappropriately targets the chiropractic profession. Several commenters opined that the rule was highly discriminatory and will support litigation if the amendment is implemented.

RESPONSE: As noted above in response to an earlier comment, the exemption from the daily maximum for osteopathic manipulation treatment was not amended in the proposed rulemaking and thus the comments are outside the scope of the proposal. The Department intends to address this issue in future rulemaking.

COMMENT: One commenter stated the amendment has the affect of relegating chiropractors to the same level as physical therapists who do not have physician status. The commenter noted that the proposal not only grants osteopaths and medical doctors higher fees, but also exempts services performed by them from the \$90.00 a day cap. One commenter declared that the medical fee schedule and the cap of \$90.00 per day is inconsistent with the ability of chiropractors to render quality care to patients injured in motor vehicle accidents. One commenter stated that under the \$90.00 daily cap the treating doctor must choose not what is in the patient's best interest, for quickest and best resolution of their injuries, but what services on that day will be reimbursed. For providers to continue to offer these much needed services to the patient, without hope of some level of reimbursement, constitutes financial suicide.

RESPONSE: As noted above in response to an earlier comment, the exemption from the daily maximum for osteopathic manipulation treatment was not amended in the proposed rulemaking and thus the comment is outside the scope of the proposal. The Department intends to address this issue in future rulemaking.

COMMENT: One commenter stated that the chiropractic profession is based upon spinal manipulation adjustment models and that chiropractors spend the most time and effort of all professions in developing a skill required to render these services. The commenter noted that historically osteopaths based their model on spinal manipulation, but that is no longer the case, and that their training in these procedures pales in comparison to a doctor of chiropractic. In regard to medical doctors, their training is extremely limited in this art and science and in many cases obtained from weekend seminars. The commenter stated it makes their point not to belittle other professions, but because the commenter fails to understand how the Department can assign a greater reimbursement level to similar services when performed by osteopaths or medical doctors. The commenter went on to question how it is possible that the chiropractic profession, which has more knowledge, training, and experience, is actually reimbursed less than another profession with less experience, knowledge and training. The commenter believes that this is bad public policy, potentially illegal, and appears to target the chiropractic profession in a discriminatory fashion.

RESPONSE: As noted above in response to an earlier comment, the exemption from the daily maximum for osteopathic manipulation treatment was not amended in the proposed rulemaking and thus the comment is outside the scope of the proposal. The Department intends to address this issue in future rulemaking.

COMMENT: One commenter questioned the clinical and procedural rationale for the continued inclusion of chiropractic manipulative treatment codes 98940 to 98942 in the \$90.00 daily maximum while excluding from the daily maximum osteopathic manipulative treatment 98925 - 98929 when actually performed by the osteopathic physician or medical doctor. The commenter opined that this portion of the proposal is inherently discriminatory to the chiropractic profession and not in the best interest of the patients or the public. One commenter strongly urged that both osteopathic and chiropractic manipulative treatment, when actually performed by the osteopathic physician, medical doctor or chiropractor, not be subject to the \$90.00 daily maximum. One commenter suggested that the Department rework the section regarding daily limits and exclude chiropractic manipulation from the all-inclusive cap in the same way that other physicians' manipulation is excluded.

RESPONSE: As noted above in response to an earlier comment, the exemption from the daily maximum for osteopathic manipulation treatment was not amended in the proposed rulemaking and thus the comment is outside the scope of the proposal. The Department intends to address this issue in future rulemaking.

COMMENT: One commenter was concerned with the inclusion of codes 98940, 98941 and 98942, involving chiropractic manipulation in Appendix 6, thus making the code subject to the daily maximum. The commenter stated that the above referenced chiropractic codes are equivalent to 98925, 98926 and 98927 which are provided by osteopathic physicians. The commenter stated that it is well established that the concept of relative value units (RVU) are the basis for fee calculations in the health care field and establishes parity in fees between various specialties, that national studies

done by the American Medical Association and Health Care Financing Administration found that fees between osteopathic and chiropractic physicians differ by only 8.25 percent in the average RVU for equivalent services, yet, when manipulation is performed by chiropractors or osteopaths, the osteopathic manipulation is exempt from the daily maximum.

RESPONSE: As noted above in response to an earlier comment, the exemption from the daily maximum for osteopathic manipulation treatment was not amended in the proposed rulemaking and thus the comment is outside the scope of the proposal. The Department intends to address this issue in future rulemaking.

COMMENT: One commenter stated that reimbursement for chiropractic manipulation is already inaccurately reimbursed in the present fee schedule. By including chiropractic manipulation within the daily maximum, the Department has further artificially lowered the reimbursed value of this service. The commenter stated that it was concerned that artificially lowered fees would potentially lead to fraud and creative billing; that the commenter has seen the beginning of new types of fraud including aberrations of multidisciplinary practice structures and sham ownership of so-called medical practices which creatively attempt to circumvent the restrictions on reimbursement for chiropractic services by involving medical and/or osteopathic practitioners who are not actually providing patient care. The commenter recommends that the Department either remove chiropractic manipulation codes from the daily maximum or include all manipulative codes under the daily maximum. The commenter stated that the first option would be the most appropriate because both chiropractic and osteopathic manipulations are performed by a physician. Further, the average RVU's for both chiropractic and osteopathic manipulation are at least 100 percent higher than the average of the remainder of the CPT codes, thus indicating a much higher level of service; that the difference in the average of the chiropractic to osteopathic manipulation RVU's is only 8.25 percent, which does not justify arbitrarily separating the services into grossly different categories for reimbursement; and lastly, the change would reduce the incentive for creative billing, practice structure aberrations, and fraud.

The commenter noted that including all manipulative codes under the daily maximum might reduce the incentives for creative billing, practice structure aberrations, and fraud. However, it would place an artificially low value on services performed by both chiropractic and osteopathic physicians.

RESPONSE: Neither the fees on the physician's fee schedule nor the exemption from the daily maximum for osteopathic manipulation treatment were amended in the proposed rulemaking and thus the comment is outside the scope of the proposal. The Department intends to address this issue in future rulemaking.

COMMENT: Several commenters stated that the lower reimbursement rate for chiropractic manipulation as compared to osteopathic manipulation, the exclusion of osteopathic medical doctors from the \$90.00 daily cap and the exclusion of soft tissue injuries as a condition which may require "extraordinary time and effort for effective

treatment” discriminates against the chiropractic profession and will be formally opposed.

RESPONSE: Neither the fees on the physician’s fee schedule nor the exemption from the daily maximum for osteopathic manipulation treatment were amended in the proposed rulemaking and thus the comment is outside the scope of the proposal. The Department intends to address this issue in future rulemaking.

COMMENT: One commenter stated that doctors of chiropractic have physician status, that they receive training, skilled testing, and state licensure that classifies them as physician level services; and that the proposal which attempts to pay a doctor of chiropractic at a lesser level of reimbursement than a medical doctor or osteopath for performing the same type of service is inappropriate. The commenter continued that since the proposed regulation exempts medical doctors and osteopaths from benefit caps it must also exempt doctors of chiropractic because of their physician status. It is inaccurate to compare a doctor of chiropractic to a physical therapist, as physical therapists do not have physician status and cannot diagnose a patient.

RESPONSE: As noted above in response to the earlier comment, the exemption from the daily maximum for osteopathic manipulation treatment was not amended in the proposed rulemaking and thus the comment is outside the scope of the proposal. The Department intends to address this issue in future rulemaking.

COMMENT: One commenter stated that regulatory changes should not be used to discriminate against any particular health care provider group; that the insuring public in New Jersey deserves options for choosing health care under their personal injury protection coverage; that there should not be any regulation or policy in place that discourages or intimidates a patient from receiving proper care from a doctor of chiropractic; and that insurers have a fiduciary responsibility to understand billing and coding principles and should not seek regulation to fix claim severity issues within their control.

RESPONSE: As noted above in response to the earlier comment, the exemption from the daily maximum for osteopathic manipulation treatment was not amended in the proposed rulemaking and thus the comment is outside the scope of the proposal. The Department intends to address this issue in future rulemaking.

COMMENT: One commenter stated that the impact of exempting medical and osteopathic physicians from the daily maximum allowable would not save insurers or patients any money. The commenter stated that enabling these groups to bill in addition to the daily maximum fee would only serve to increase insurance premiums for the remainder of New Jersey citizens. Since it is the intent of the legislation to reduce the exorbitant cost of automobile insurance in New Jersey, allowing select groups to bill beyond the daily maximum cannot be consistent with the intent of the law.

RESPONSE: As noted above in response to the earlier comment, the exemption from the daily maximum for osteopathic manipulation treatment was not amended in the

proposed rulemaking and thus the comment is outside the scope of the proposal. The Department intends to address this issue in future rulemaking.

COMMENT: One commenter stated that the proposed regulation making manipulation therapy by medical and osteopathic physicians exempt from the daily cap would have a negative job impact because it would create confusion within the claims departments and precertification areas. This exemption would require additional background checks, documentation and substantial employee hours to ensure that the appropriate exception to the daily maximum fee is being accepted. Increasing the amount of employee hours and the expense cannot be consistent with reducing insurance rates and streamlining the paperwork process.

RESPONSE: As noted above in response to the earlier comment, the exemption from the daily maximum for osteopathic manipulation treatment was not amended in the proposed rulemaking and thus the comment is outside the scope of the proposal. The Department intends to address this issue in future rulemaking.

COMMENT: One commenter questioned the rationale behind the continued inclusion of chiropractic manipulation treatment 98940 - 98942 in the \$90.00 daily minimum while excluding osteopathic manipulative treatment 98925 - 98929 when actually performed by the osteopathic physician or medical doctor from the daily maximum. One commenter suggested that both osteopathic and chiropractic manipulative treatment when actually performed by the osteopathic physician, medical doctor or chiropractor, not be subject to the \$90.00 daily maximum. One commenter strongly opposed the amendment in that it would reduce the number of procedures subject to the \$90.00 daily cap to those commonly performed by chiropractors, yet exempt from the cap services performed by osteopaths and medical doctors. One commenter was supportive of the amendments because they will make it possible for patients with severe brain injury to receive different services from different therapists occurring on the same day. This practice is consistent with current standards of care for the rehabilitation of persons with acquired brain injury. One commenter suggested that code 97110 (therapeutic exercise) be removed from the daily maximum as this is commonly provided to persons with neurologic and cognitive impairments as a component of their rehabilitation and may be provided by different therapists directed at different aspects of the patient's disability and treatment.

RESPONSE: As noted above in response to the earlier comment, the exemption from the daily maximum for osteopathic manipulation treatment was not amended in the proposed rulemaking and thus the comment is outside the scope of the proposal. The Department intends to address this issue in future rulemaking. Concerning the suggestion to remove code 97110 from the cap because it is commonly provided to persons with neurologic and cognitive impairments, such a change cannot be made on adoption as it would be a significant change requiring additional notice and public comment. The Department will review whether it is appropriate to remove it from the daily maximum.

COMMENT: One commenter questioned the rationale behind specifically excluding soft tissue injuries as a condition that may require extraordinary time and effort for effective treatment. A large body of evidence and professional literature demonstrates that soft tissue injuries can be very severe and debilitating and can certainly require extraordinary time and effort for effective treatment. The commenter stated that if a patient has severe, acute whiplash, that care might be necessary more than once in a single day. If such care is accompanied by proper documentation, then soft tissue injuries should be treated as any other condition and not excluded.

RESPONSE: The Department does not agree with the commenter. The amendments to the rule provide that an insurer may waive the daily maximum, "where the severity or extent of the injury is such that extraordinary time and effort is needed for effective treatment." The Department does not believe that treatment of soft-tissue injuries is likely to require such a waiver but the language of the rule does not prohibit it.

COMMENT: Several commenters questioned the rationale behind specifically excluding soft tissue injuries from the exemption from the daily maximum. One commenter stated that in certain instances soft tissue injuries may also require extraordinary time and effort for effective treatment and if such additional time is properly accompanied by documentation, soft tissue injuries should be treated as any other condition and not be excluded. One commenter questioned why a soft tissue injury was excluded as a condition that may require extraordinary time and effort for effective treatment. One commenter stated that the amendment targets only chiropractors because soft tissue injuries are excluded from consideration for exemption from the cap, although there are various instances where the application of chiropractic care would meet the exemption. One commenter stated that the Department is under the impression that injuries to soft tissues of the body are not significant. The commentator said that a patient with a significant disc or nerve injury has a serious, painful and functionally limiting injury. The commenter noted that under the proposal, this type of injury is insignificant, which implies that the treatments relating to the care for these injuries is not difficult, time consuming or expensive to render. One commenter asked whether when a patient has a disc and nerve injury to both the cervical and lumbar spines, which area should a chiropractor elect to treat on a given day. One commenter stated that treatment of significant injuries, including those of the soft tissues of the body which require extraordinary time and effort, should be eligible for reimbursement that exceeds the \$90.00 daily cap.

RESPONSE: As noted above in response to the previous comment, the rule does not exclude waiver of the daily maximum for any specific type of injury. The examples cited in the rule refer to, "non soft-tissue injuries to multiple areas of the body." The purpose of amending the waiver provision was not to suggest that soft tissue injuries are insignificant. However, the daily maximum for the listed CPT codes has been in effect since May, 2001. The purpose of the amendments was to provide a better definition of when the daily maximum can be waived.

COMMENT: One commenter was concerned with the all-inclusive nature of the daily limit. The commenter stated there are many patients who have multiple types of injuries that require physical medicine treatments and that cannot be treated by the same provider. The \$90.00 daily cap does not address this. The commenter gave an example of a patient who has both a neck injury and a knee injury. The commenter stated that if the patient sees a chiropractor and a physical therapist on the same day and all treatment is lumped into the daily limit, only one provider would get paid. The decision on who gets paid is arbitrarily left to the insurance company's claims department. The commenter stated that the patient is then forced to be treated on different days, which is an added burden to the patient's lifestyle, or the patient must pay out-of-pocket for the treatment, which is an unnecessary financial burden. One commenter stated that there should be some ability to allow entirely separate injuries to be treated on the same day and still be reimbursed to providers. The commenter does not suggest that multiple providers should treat the same injury, but that the rules should take into account unrelated injuries that are often suffered by a motorist.

RESPONSE: The comment is directed to the concept of the \$90.00 daily maximum, which was not amended in the proposal and as such is outside the scope of this rulemaking.

COMMENT: Several commenters submitted similar letters stating that the list of procedures subject to the \$90.00 daily cap should be further revised so that services that involve multiple therapies due to multiple traumas and injuries on different parts of the body be exempt from the cap. The commenters stated that many disciplines use the same codes and when multiple therapies utilize the same codes on the same day, once the \$90.00 maximum is reached, no further reimbursement is allowed. The result is that if a patient received physical, occupational and cognitive/neuro therapy in one day, while the services are not redundant, identical codes may be used and the result is payment of only a fraction of the cost for one of the therapies and absolutely no reimbursement for any other therapy.

RESPONSE: The Department believes that the waiver provision adequately addresses the circumstances where multiple injuries necessitate treatment that exceeds the daily maximum.

COMMENT: One commenter was concerned about the \$90.00 per day cap and questions how one treating provider is supposed to control and know when his or her patient is seeing another independent treating provider on the same day for similar services. The commenter questioned which provider gets paid first if two independent providers provide similar services on the same day and the physical medicine and rehabilitation services exceed the \$90.00 per day cap. The commenter went on to question whether it is fair for one provider to get payment preference over another and suggested the rules need more clarity.

RESPONSE: The amendments to the rule did not change the basic provisions of the daily maximum and, therefore, the comment is outside the scope of this rulemaking.

COMMENT: Several commenters submitted similar letters stating that there may be cases in which CPT 97159 is used by separate therapists providing cognitive neurological therapy as well as physical and occupational therapy all in the same day. The commenters noted that cognitive neurological therapy for brain trauma is very different from physical therapy for orthopedic injuries. Cognitive neurological therapy involves intensive and often time consuming treatment and can cost upwards of \$400.00 per day. The commenters further noted that the \$90.00 daily cap does not allow for consideration of factors affecting the nature of the care or the cost or intensity of treatment such as diagnosis, severity of injury, or patient's age. Geriatric and pediatric patients often require one-to-one therapy and extra hands-on care.

RESPONSE: The commenter has misunderstood the proposal. Cognitive Therapy, CPT 97159, is no longer included in the list of procedures subject to the daily maximum.

COMMENT: One commenter noted that a patient's diagnosis is a critical factor when reporting CPT codes 97532 and 97533. The commenter stated that these codes alone do not accurately identify treatment rendered for serious injuries or a diagnosis correlating with a brain injury. The commenter further stated that the determination of a "serious traumatic injury" and the decision to reimburse a health care provider in excess of the current \$90.00 daily maximum allowance cannot be adequately evaluated when only the code is reported.

RESPONSE: The Department believes that the commenter has misunderstood the amendment proposed to the fee schedule rule. CPT codes 97532 and 97533 are no longer included in those codes subject to the daily maximum and therefore the waiver would not apply.

COMMENT: One commenter stated that confusion on the part of claims personnel and payers will continue to exist if the language in the rule continues to refer to the sequence of CPT codes 97001 through 98943. The commenter stated that claims personnel and/or payers have remembered only the sequence, not that there are exceptions. The commenter urges the Department to adopt language that does not refer to any sequence of numbers, but only refers to Exhibit 6 as the CPT codes that are subject to the daily maximum.

RESPONSE: The rule refers to Appendix, Exhibit 6 as the source of the codes that are subject to the daily maximum.

COMMENT: One commenter stated that it is absurd for the Department to base the fee schedule on reimbursements paid by other carriers. No other carrier requires the level of staff and physician involvement in these areas as does personal injury protection. In addition, participation with many of the carriers that have lower levels of reimbursement also increases the office patient load in exchange for the lower level of reimbursement. The commenter stated that the current reimbursement for a single area of spinal

manipulation by a chiropractor is consistent with reimbursement from Medicare. The Medicare level of reimbursement for personal injury protection patients was specifically not the goal of the automobile reform legislation.

RESPONSE: The Department has not adjusted any fees in the physician's fee schedule in the proposal and, therefore, the comment is outside the scope of the rulemaking.

COMMENT: One commenter noted that CPT code 97532 - cognitive therapy - is listed in the CPT manual under physical medicine and rehabilitation, but that it differs from physical rehabilitation. The commenter stated that in the past, cognitive therapy was listed under unusual procedures. Over the last 25 years, more patients are surviving brain injuries in one form or another because of sophisticated trauma teams. However, the patients are left with cognitive deficits in long-term memory, short-term memory, attention-concentration and problem solving. The commenter noted that in the 1980s, in-patient rehabilitation facilities began emerging to place these patients, since that was a better alternative than nursing homes to treat the more severe injuries. However, outpatient facilities also emerged to handle mild to moderate injuries. The commenter noted that cognitive therapy, in order to be truly beneficial, needs to be done five days a week for severe injury and two to three days a week for mild to moderate injury; each session should be scheduled for two hours, one on one with the patient, and that this does not constitute extraordinary time and effort since it has been the standard for effective treatment. Since a patient may be in need of physical, speech or occupational therapies rendered on the same day in another facility, that provider should not be penalized by allowing only a daily maximum of \$90.00.

RESPONSE: The Department believes that the commenter has misunderstood the amendment proposed to the fee schedule rule. CPT code 97532 is no longer included in those codes subject to the daily maximum.

COMMENT: One commenter requested clarification as to how codes not listed in Exhibit 6 are to be reimbursed. The commenter stated that those codes are to be reimbursed according to the fee schedule with the application of the multiple procedure reduction formula and that if this is the case, it should be indicated in the rule.

RESPONSE: The Department believes that the language of N.J.A.C. 11:3-29.4(f) states clearly that except as provided in subsection (m) (the daily maximum), the multiple procedure reduction formula applies.

COMMENT: One commenter recommended that the specific language concerning the application of medical fee schedules at N.J.A.C. 11:3-29.4 be clarified so that it is more readily apparent that codes not listed in Appendix 6 are not subject to the daily maximum.

RESPONSE: The Department does not agree with the commenter. The language in N.J.A.C. 11:3-29.4(m) states clearly that only the codes listed in Exhibit 6 are subject to the daily maximum.

COMMENT: Several commenters submitted similar letters that supported the Department's attempt to create stronger language regarding payers' options to reimburse providers above the \$90.00 daily cap or other fee schedule when the nature of an injury warrants more complex care or when a patient receives multiple therapies. The commenters believe stronger language is needed that requires payers to reimburse above the daily maximum rather than simply not prohibiting payers from providing reimbursement that exceeds the \$90.00 daily cap or fee schedule. The commenters believe that since the regulatory language does not explicitly state that a waiver is appropriate, payers will unilaterally deny reimbursement above the fee schedule. Without the specific requirement that the payers must reimburse above the \$90.00 daily cap in certain instances, payers will not be inclined to offer fair and adequate reimbursement to providers.

RESPONSE: The Department does not agree with the commenters that the waiver of the daily maximum should be required in the rule. In determining whether to reimburse above the daily maximum, insurers are making determinations of medical necessity similar to those required for decision point review and precertification. Moreover, providers have the opportunity to make an internal appeal to the insurer and ultimately to take the matter to arbitration if they do not agree with the insurer's determination.

COMMENT: One commenter suggested that the Department adopt more specific language so that carriers are not given the right to decide if they want to, or feel like paying for extraordinary services. The commenter noted that to ask the carriers to decide whether they will allow greater reimbursement is much like the old saying of "the fox guarding the hen house."

RESPONSE: The Department does not agree with the commenter. The Department expects insurers to apply the same principles of medical necessity in determining whether to grant a waiver that they do in reviewing decision point and precertification requests and be able to support their decisions. The provider also must demonstrate that the additional treatment is needed. To take away the ability of insurers to make a case by case determination on these issues would make the exception the rule.

COMMENT: One commenter recommended that the language of the proposed amendment regarding a payer's option to reimburse above the daily cap when the nature of the injury warrants complex care be changed so that the payers are "required" to reimburse rather than simply "not prohibited." The commenter stated that the language as proposed is likely to create a situation of repeated denials, appeals and reviews, or restrict the ability of patients with catastrophic injuries to receive continuous care consistent with the requirements of their condition.

RESPONSE: The Department does not agree with the commenter's suggestion. As stated above in response to the previous comment, the determination to permit the waiver of the daily cap is a medical necessity decision like others administered under

PIP. The “denials, appeals and reviews” referred to are the processes established to give providers the opportunity to challenge decisions made by insurers.

Federal Standards Statement

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

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

11:3-29.4 Application of Medical Fee Schedules

(a) - (l) (No change from proposal.)

(m) The daily maximum allowable fee shall be \$90.00 for the Physical Medicine and Rehabilitation CPT codes listed in subchapter Appendix, Exhibit 6, incorporated herein by reference, that are commonly provided together. The daily maximum applies when such services are performed for the same patient on the same date. However, an insurer is not prohibited from reimbursing providers in excess of the daily maximum where the severity or extent of the injury is such that extraordinary time and effort is needed for effective treatment. Such injuries could include, but are not limited to, severe brain injury and non-soft-tissue injuries to more than one part of the body. Treatment that the provider believes should not be subject to the daily maximum shall be billed using modifier -22 as designated in CPT for unusual procedural services. Unless already provided to the insurer as part of a decision point review or precertification request, the billing shall be accompanied by documentation of why the extraordinary time **[for]** **and** effort for treatment was needed.