44 NJR 11(1)
November 5, 2012
Filed October 18, 2012

INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

OFFICE OF PROPERTY AND CASUALTY

Personal Injury Protection

Personal Injury Protection Benefits: Medical Protocols; Diagnostic Tests

Personal Injury Protection Dispute Resolution

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

Adopted New Rules: N.J.A.C. 11:3-4.7A, 4.7B, 29.5, and 11:3-29 Appendix, Exhibits 1 through 7

Adopted Amendments: N.J.A.C. 11:3-4.2, 4.4, 4.7, 4.8, 4.9, 5.2, 5.4, 5.5, 5.6, 5.12, and 29.1 through 29.4

Adopted Repeals: N.J.A.C. 11:3-29 Appendix, Exhibits 1 through 7

Proposed: August 1, 2011 at 43 N.J.R. 1640(a).

Notice of Proposed Substantial Changes upon Adoption to Proposed New Rules, Amendments, and Repeals: February 21, 2012 at 44 N.J.R. 383(a).

Adopted: October 9, 2012 by Kenneth E. Kobylowski, Acting Commissioner, Department of Banking and Insurance.

Filed: October 11, 2012 as R.2012 d.187, **with substantial changes** to proposal after additional notice and public comment, pursuant to N.J.S.A. 52:14B-10 and **with**

substantial and technical changes not requiring additional notice and opportunity for comment (see N.J.A.C. 1:30-6.3)**.**

Authority: N.J.S.A. 17:1-8.1, 17:1-15.e, 17:29A-14.c(4), 17:33B-42, 39:6A-1.2, 39:6A-3.1, 39:6A-4, 39:6A-4.3, 39:6A-5.1, 39:6A-4.6, 39:6A-5.2, and 39:6A-19.

Effective Date: November 5, 2012.

Operative Date: January 4, 2013 for all amendments, repeals, and new rules with the exception of the amendments to N.J.A.C. 11:3-4.7(c)6 and new rule N.J.A.C. 11:3-4.7B, which shall be operative November 5, 2013.

Expiration Date: June 7, 2013.

Summary of Public Comments and Agency Responses:

The original rule proposal was submitted by the New Jersey Department of Banking and Insurance (Department) for publication in the August 1, 2011 New Jersey Register. Upon publication and public notice, numerous comments were received during the initial 60-day comment period following the publication of the original rule proposal. Those comments are summarized below, grouped in separate sections depending upon whether the comment prompted a modification to the original rule proposal or addressed a provision that was subsequently modified in response to another comment. Additionally, the Department received additional public comments upon publication of the notice of proposed substantial changes upon adoption to proposal (notice of proposed substantial changes), which are included, along with the Department's responses thereto, in a separate section below.

1. **Comments Received During Initial Comment Period Giving Rise to Substantial**

Changes in Proposal upon Adoption

In response to some of the comments received during the initial public comment period after promulgation of the original rule proposal, the Department proposed to make substantial changes to the proposal, subject to additional notice and public comment, in accordance with newly-promulgated regulatory procedures codified at N.J.S.A. 52:14B-4.10. The proposed substantial changes upon adoption, and the comments prompting them, were promulgated in a notice of proposed substantial changes upon adoption, published in the February 21, 2012 New Jersey Register, and are summarized below. Comments were received from:

Gail Law, Administrator	Essex Specialized Surgical Institute
Joyce Kozacik	Essex Specialized Surgical Institute
Dr. Pancu	Bergen Anesthesia and Pain Management
Dr. Marc Ohaniam	Bergen Anesthesia and Pain Management
Dr. Grigorescu	Bergen Anesthesia and Pain Management
Dr. Peter Popa	Bergen Anesthesia and Pain Management
Dr. David Epstein	Bergen Anesthesia and Pain Mgmt.
Beatrix Kelemen	Hudson Crossing Surgery Center
Susan Bagnuolo	Hudson Crossing Surgery Center
Betsy Cameron	Eastern Ortho. Associates
Lyn Boyle	Eastern Ortho. Associates
Brian J. Bauer, MD	Eastern Ortho. Associates
Jeffrey K. Steuer, MD	Eastern Ortho. Associates
Sabina Smith	Gotham City Orthopedics
Jocelyn Lichrenbeg	Gotham City Orthopedics
Belbys M. Santiago	Gotham City Orthopedics
Michael Grenis, MD	Princeton Surgiplex
Pat Price, OR Nurse	Princeton Surgiplex
Ann Disbrow, PACU Nurse	Princeton Surgiplex
Patty Plas, OR Nurse	Princeton Surgiplex

Donna Haines	Princeton Surgiplex, LLC
Cheryl Baldino	Princeton Surgiplex, LLC
Terri Mair	The Endo Center at Voorhees
Narda McBride	The Endo Center at Voorhees
Deborah Ash	The Endo Center at Voorhees
Augustine Turnier, Physician	The Endo Center at Voorhees
Melville Ackerman, Physician	The Endo Center at Voorhees
Linda Walzer	The Endo Center at Voorhees
Gary H. Levin, Med. Dir.	The Endo Center at Voorhees
Joseph Savon, MD	The Endo Center at Voorhees
Juluru Rao, MD	Liberty Ambulatory Surgery Center
Anroy Ottley, MD	Liberty Ambulatory Surgery Center
Guillem Gonzalez-Lomas	Liberty Ambulatory Surgery Center
Alexander Visco. MD	Liberty Ambulatory Surgery Center
Gwenn Kopp, BOM	Liberty Ambulatory Surgery Center
Miriam Hernandez, RN, DON	Liberty Ambulatory Surgery Center
Sarah Bloomenstiel	Liberty Ambulatory Surgery Center
Leticia Escobar	Journal Square Surgical Center
Marine Aminova	Journal Square Surgical Center
Mushtaq Khan	Journal Square Surgical Center
Helen Lopez	Journal Square Surgical Center
Gary Di Nardo, CEO	Journal Square Surgical Center
Keith DeNardo, VP	Journal Square Surgical Center
Jamie Martucci	Journal Square Surgical Center
Guillarmo Ortiz, MD	Morris County Surgical Center
Steven Ware, MD	Morris County Surgical Center
Brandon Ma, MD	Morris County Surgical Center
Robert Petrucelli, MD	Morris County Surgical Center
Joann Somers, MD	Morris County Surgical Center
Andrei Buna, MD	Morris County Surgical Center
Marc Simon, MD	Morris County Surgical Center
Richard Rothenberg, MD	Morris County Surgical Center
Norman San Augustin, MD	Morris County Surgical Center
Irving Peyser, MD	Morris County Surgical Center
David Pizzano, MD	Morris County Surgical Center
Michael Patsis, MD	Morris County Surgical Center
Tina Petillo, MD	Morris County Surgical Center
Cem Omay, MD	Morris County Surgical Center
Joseph Maugeri, MD	Morris County Surgical Center
Regina Kaplan, MD	Morris County Surgical Center
Francis Jampol, MD	Morris County Surgical Center

Lawrence Friedman, MD	Morris County Surgical Center
Steven Haskel, MD	Morris County Surgical Center
Kim Spagnola, MD	Morris County Surgical Center
Vincent Emiliani, MD	Morris County Surgical Center
Warren Galeos, MD	Morris County Surgical Center
Eliyahu Fuchs, MD	Morris County Surgical Center
Vincent Cubelli, MD	Morris County Surgical Center
John Soriano, MD	Morris County Surgical Center
Irvin Bonder, MD	Morris County Surgical Center
Erwin Bulan, MD (Parsippany, NJ)	Morris County Surgical Center
Adam Berman, MD	Morris County Surgical Center
Edward Barbarito, MD	Morris County Surgical Center
Thomas A. Gesen, MD	Morris County Surgical Center
Catherine Mannon	Morris County Surgical Center
Nicholas Albicocco, MD	Morris County Surgical Center
Cindya Coffey	Morris County Surgical Center
Sheena Spence	Morris County Surgical Center
Gavin Abrahams	Morris County Surgical Center
Rosa Toro	Morris County Surgical Center
Shelly Palomares, RN	Morris County Surgical Center
April Rockey, RN	Morris County Surgical Center
Linda Eggers, RN	Morris County Surgical Center
Tracy Fitzgerald, RN	Morris County Surgical Center
Anna Maria Grimaldi	Morris County Surgical Center
Joseph Wallis, MD	Morris County Surgical Center
Elaine Dahl, RN	Morris County Surgical Center
Lisa Pyper, RN	Morris County Surgical Center
Desirree Weber	Morris County Surgical Center
Rosario Ballestas, RN	Morris County Surgical Center
Hakan Kutlu, MD	Morris County Surgical Center
Delores Boyle	Morris County Surgical Center
Linqiu Zhou, Assit. Prof.	Woodbury Spine
Even D. O'Brien, Phys.	Woodbury Spine
William Friedman, CEO,	Meadows Surgery Center
Joyce Caning	Meadows Surgery Center
Julie Musto, SN	Specialty Surgery of Middletown
Melissa Condo	Specialty Surgery of Middletown
Eileen Zalewski	Specialty Surgery of Middletown
Kristi Huffert, RN	Specialty Surgery of Middletown
Jerry DiPaola	Specialty Surgery of Middletown
Danielle Pyzik	Specialty Surgical Center of N. Brunswick
Michalle Stanley, RN	Specialty Surgical Center of N. Brunswick

Ludvinia Libarnes, RN, Dir. Of Nursing	American Surgical Center of W. Orange
Denise Thorne, RN	American Surgical Center of W. Orange
Ira Klein, MD	American Surgical Center of W. Orange
Gail Law, Administrator	Essex Specialized Surgical Institute
Joyce Kozacik	Essex Specialized Surgical Institute
Brian Weiner, MD, Pres.	Manalapan Surgery Center
Cynthia Vagnuolo, RN	Manalapan Surgery Center
Denise DiPierri, Exec. Dir.	Manalapan Surgery Center
Claudia Neme	Surgicare of Central Jersey
Allan B. Cohen, MD	Surgicare of Central Jersey
Ana DaSilva	Surgicare of Central Jersey
Shilise Walker	Surgicare of Central Jersey
Mary E. Vasquez	Surgicare of Central Jersey
Denise McNair	Surgicare of Central Jersey, Inc.
Patricia Taber	Surgicare of Central Jersey, Inc.
Linda Kollar	Surgicare of Central Jersey, Inc.
Susan Rowan, Dir. Of Nurses	Hasbrouck Heights Surgery Center
Sixto Arroyo	Hasbrouck Heights Surgery Center
Joan Lange, RN	Advanced Spine Surgery Center
Diane Scott, RN	Advanced Spine Surgery Center
Elizabeth Tkac	Advanced Spine Surgery Center
Jenna DeStefano	Advanced Spine Surgery Center
Kathryn Caputo	Advanced Spine Surgery Center
Minzhong Peng	Advanced Spine Surgery Center
Anne Finnerty	Advanced Spine Surgery Center
Cynthia Vogler	Advanced Spine Surgery Center
Andrej Zembrzuski	Advanced Spine Surgical Center
Jessica Santiago	Saddle Brook Surgicenter, Inc.
Ronald Sollitto	Saddle Brook Surgicenter, Inc.
Debra Acker, Adm. Supervisor	Saddle Brook Surgicenter, Inc.
Peter P. Retalis	Saddle Brook Surgicenter, Inc.
Rosemary Franco	Saddle Brook Surgicenter, Inc.
Janie Maroldi	Saddle Brook Surgicenter, Inc.
Joan Balducci	N. Jersey Center for Surgery
Maree Casatelli	N. Jersey Center for Surgery
Diane Cole	N. Jersey Center for Surgery

Brunilda Rios	N. Jersey Center for Surgery
Barbara Austin	N. Jersey Center for Surgery
Carolyn Bevelheimer	N. Jersey Center for Surgery
Kristina Blaszak	N. Jersey Center for Surgery
Patti K. Schwartz	N. Jersey Center for Surgery
Trisha Byers	N. Jersey Center for Surgery
Nancy Snover	N. Jersey Center for Surgery
Elizabeth Pergola	N. Jersey Center for Surgery
Alyse Bellomo, MD	Bergen Gastroenterology
Anthony Delillo, MD	Bergen Gastroenterology
Crystal Broussard, MD	Bergen Gastroenterology
Robert Pittman, MD	Bergen Gastroenterology
Holly Chen, MD	Bergen Gastroenterology
Stephen Margulis, MD	Bergen Gastroenterology
Robert Levine, MD	Bergen Gastroenterology
Ron Turk	Bergen Gastroenterology
Eric Avezzano, MD	Bergen Gastroenterology
Arlene Gleeson	Bergen Gastroenterology
Jackie Cepparulo	Essex Surgical
Linda Spitaletta	Essex Surgical
George C. Peck, Jr., MD	Essex Surgical
Richard K. Chessler, MD, Pres.	Scherl, Chessler, Zingler, Spinnell & Meininger
Barry M. Zingler, VP	Scherl, Chessler, Zingler, Spinnell & Meininger
Michael A. Gailie	Scherl, Chessler, Zingler, Spinnell & Meininger
Marc A. Fiorillo, MD	Scherl, Chessler, Zingler, Spinnell & Meininger
Mitchell K. Spinnell, MD	Scherl, Chessler, Zingler, Spinnell & Meininger
Michael E. Meininger	Scherl, Chessler, Zingler, Spinnell & Meininger
Elizabeth Convery, RN	Teaneck Surgical Center
Jonathan Archer, MD	Teaneck Surgical Center
John Owens, MD	Teaneck Surgical Center
Jen Lee, MD	Teaneck Surgical Center
Dr. Joseph R. Zerbo	Lowe Greenwood Zerbo Spinal Assoc.
James G. Lowe, MD	Lowe Greenwood Zerbo Spinal Assoc.
S. Bergman	Millennium Surgical Center

Scott Bergman	Millennium Surgical Center
Sharon DeMato	N.J. Association of Ambulatory Surgery Centers
Mike G.	N.J. Association of Ambulatory Surgery Centers
Roesann Benanti	Englewood Endoscopic Associates
Carmen River	Englewood Endoscopic Associates

Frank A. Stiso, D.C., FICC, CCSP
Shannon M. Mulvey, D.C.
David C. Corrado, D.C.
Robert Conti, D.C.
Albert Stabile, President, New Jersey Board of Chiropractic Examiners
Nicholas Rizzitello, D.C.
Steven G. Clarke, D.C., President, Association of New Jersey Chiropractors
Jeffrey B. Randolph, General Counsel, Association of New Jersey Chiropractors
Melissa McGarry, Program Director, Coventry Auto Solutions
Conti Chiropractic Center
Neil J. Schneider, D.C.
David Bertone, PT, DPT, OCS
Catherine Delseni
Frank Gasparovic
Daniel E. Rosner, Esq.
Andrew F. Garruto, Esq.
Laurie A. Clark, Counsel for the NJ Association of Osteopathic Physicians and Surgeons
Ken Mailly, Executive Director, NJ Society of Independent Physical Therapists
Thomas Osterman, Jr., D.C.,
Robert Mazza, D.C.
Paul R. Franz, D.C.
Harshad Patel
Debra Lienhardt, Counsel to New Jersey Association of Ophthalmologists
Michael F. Midlige, Esq.
John D. Fanburg and Mark Manigan, Counsel for New Jersey Association of Ambulatory Surgery Centers
Craig Goldstein, CSG
Premier Prizm Solutions
Georgia Flamporis, Counsel to Allstate New Jersey/Encompass New Jersey
IDS Property Casualty Insurance Company
Patricia Ross, BA, RN, CCM, CPC
Robin Delgado, Vice President, Auto Injury Solutions, Inc.
Karen Richie, Manager, Regulatory Affairs, Mitchell International, Inc.
John D. Rogers, Deputy Director, Horizon Blue Cross/Blue Shield of New Jersey
Samuel G. Destito, Attorney for Nationwide Insurance

Francis C. O'Brien, Vice President and Corporate Counsel, New Jersey Manufacturers Insurance Group
Tina Petillo, D.O.
Eric Margolis, M.D.
Francis Jampol, M.D.
Robin M. Gehrmann, M.D.
William Friedman, CEO, Meadows Surgery Center
Jacqueline Jeriko, Executive Director, Hunterdon Center for Surgery
David Flamholz
Valerie Moore
Hope Maglio
Constance Quinn
Florence Reichman
Oksana Shereneeta
Zack Wertheimer
Tzvi Small, MD, FACS
Geraldine Gonzalea, RN
Victoria Scarpa
Tammy Adams
Anita Smitella, RN
Alice Carter, RN
J. Coronel, RN
Noel Arcosa, RN
Darrell L. Roach, ORT
Joseph P. Boylan
Marcy Greenblatt
Carlan Van Vost
Marc & Janet Reichman
Liliana Porras
Victoria & Mark Scarpa
Orfelina R. Diaz
Paul J. Purfierst
Debra-Ann Mannarino, RN
Susan Turner
Tito Drakeford
Jose Perez
Julian Ramirez
Jocelyn Cuffier
Linda Fajardo, RN
Rosemary Smith, RN
Lorraince Grave, RN
Linda Geraghty, RN
Dympna McGough, RN
Mary Abbey, RN
Diane Murphy, RN
Catherine Yeo, RN

Karen Bonkowski, RN
Nilda Lumbreras
Maryann Rivera, RN, MSN, CPAN
Lori Adeoba, Human Resources Manager
Diana Daimwood, Administrator
Neil S. Roth, MD, Brd. President
Elizabeth Gonzalez
Samuel Dudley
Suzanne Kelly
Leslie Baldyga, RN,OR Manager
Maria Leszkowicz, RN
William Livingston
Doreen Destefano
Anita Green, RN
Jenell Andia
Ronnie Ella
Helene Abou-Rjalli, RN
Candido Morciglio
Joanne Guarnaccia, RN
Juan Mauricio Cano, Plant Oper. Manager
Daniell Vainberg
Elizabeth Villanueva
Claudia Salcedo
Evelyn Maldonado
Niurca Machado
Brenda De La Cruz
Diana Claiborne
Suzanne Bufalini
Laurie Brett
Ingrid Bohm
Joanne Dumas
Steven Paganessi, MD, Medical Director
Arnold Bodner, MD
Jing Wu, MD
Wassem Ashraf, MD
Ling Ding Yang, MD
Joan Sweeney, RN
Jacquelyn Doll, RN
Michelle McMillan, RN
Mijeong Ju, RN
Peggy DerLee
Karen Nardo
Valerie Moore
Caterina Cam
Joyce Owen-Wascha
Irving G. Peyser, MD

Rosa Vazquez	
Dawn Crawford	
Michelle WieBel	
Laura Dattolo	
Cindy Zecher	
Amy Aronson	
Ruth Gilmore	
Irvin M. Bonder, MD	
A. A. Steinberger, MD	Metropolitan Neurosurgery Associates
Frank M. Moore, MD	
Kevin C. Yao, MD	
Marc S. Argubteanu, MD	
Howard Liss	Physical Medicine and Rehab. Center
Sara Liso	
Donald Liss	
Elizabeth Liss	
Garry Cocklin, Jr.	
Daniel Reichman	
Juliet Reichman	
Drew Sussberg	
Alexis Sussberg	
Florence Reichman	
Lisa Schotsch	
Dori Sullivan	
Kim Karydl	Kayal Orthopaedic Center, PC
Marsha Silberman	Endo-Surgi Center of Old Bridge
Shirly Eckman	
Faith F. Radler	
Suzanne C. Patrizzi	
Allen Zelr	
Evelyn Semel	
Cecilie M. Periott	
Delia Barcelo	
Sarah Jerkowitz	
Paula M. Mongae	
Lila Mudrick	
Stuart Schmidler	
Phyllis Hirsch	
Sheila Sherman	
Shari Fedler	
Florence Deutsch	
Patricia McLama	
Elaine Lukenda	
Susan Caruso	
Linda M. Kozil	
Landra M. King	

Michele L. Reid
Wendy Rodney
Michael Walsl
Daha Bendei
Adrienne J. Billay
Murray H. Roth
Richard M. Izzy
Dr. M. Patel
Dr. Pitchumoni
Jeine Langbaum
Richard H. Harrison
Paity Ann DeLouisa
Biswadev Bhattacaarma
Donald Allen
Edd Jones
Alvin Aponte
Herbert Oxman
Eleann Baibarich
Phyllis Bouman
Faye Burnstein
Mollie Huff
Glenda Huff
Doreen Huff
Joyce Toth
David C. Salvo
Barbara Thomas Suiz
Antonia Luis Dias
Luis Jorge Dias
Maureen Mancuio
Maria Traina
Mancino
Amelia Oviedo
Gasoda Riyonancin
Taid Pulsinell
Richard H. Harrison
Ana Digna Dior
Tracy Gordon
Shirley Dixon
Edward Brennan
Theresa Markiwecy
Juanita Paden
Diana Galloza
Rachel Garbinez
Anibella Milstrey
Elizabeth Nied
Cheryl Mitts

James J. Hale, MD — Langhorne Medical Center
Erwin J. Bulan, MD (Millburn, NJ)
Joseph A. Leone, MD — Amer. Soc. For Aesthetic Plastic Surg.
Juliet Wilkinson
Patricia A. Zuck
Idamiz Roman
Pam Perono
Lorraine M. Russ
Concetta Ferrara
Michell R. Zecch
Melody Dohly
Beverly J., Smith
Michelle Andolino
Marc Veillarel
Edwin R. Busch
Ochauvin Lawson
Lillian Jones
Marilyn Ceipille
Alicia Boreco
Carol Blacca
Wills Paul
Shahidah Muslim
Dr. Carmen Cerullo
Dorota Kushian
Margaret H. Zalesky
Carol Zocchi
Olga Sosa
Allison Kiley
Carolyn Williams
Diane Mullins
Debra A. Rios
Rosalind Rosalis
Claude Jackson
Gloria Kyzu
Carmen Burger
Lorraine Carhart
Lorraine Forlini
Yaia A. Perdomo
Gerdha Sainiul
Maria G. Paduci
Gercina Esteve
Virginia Guzman
Olu Elworl
Lenore Lahidus
Janice Potochney
Pamela Sawach

Doreen Dutkinitd
Marilyn Cuellar
Patricia Ruggiero
Janet Maimone
Monica A. Moore
Shannon Spilletti
Laura Francis
Michael A. Meese, MD
Brian Wade
Bonnie Brady
Steven Enpuigy
Kathryn Craig
Marie Foster
Lisa Lyons
Kate Hbitto
Carol Siefano
Mary Keller
Terri Nannibal
Diane Crowley
Susan Shafer
Ann Stock
Deanna Siegfried
Richard Siegfried
Marianna Mathews
Jason Brown
Joya Porter
Yahaira Rosann
James Puco
Elizabeth Hoson
Allyson Berowitz.
Christine Colucci-Canosa
Lori Sicard
Maria Gambol
Herbert Hayes, III
Cathy Acosta
Patricia Ruggiero
Leon Costa
Monica Brown
Jayline Nieves
John Capo
Divya Argawal
Dr. Kamal Dutta
Sharon Juliano, RN, BSN

Janice Gaccione	Ambulatory Consulting & Mgmt.
Phyllis Tutek	Center for Advanced Surg. & Pain Mgmt.
Rakesh C. Gupta	Advanced Pain Consultants

Kathy Sarno, RN, BSN, CAPA	Center for Special Sur.
Claudia Nobra-Portela	
Francine Daley, Exex. Dir.	AtlantiCare Surgery Center
Caroline Ivanovsky-Hauser	Bergen/Passaic Cataract Surg. & Laser Center
Phyllis Molnar-Tutek	
Dr. Carney DeSarno	
Jeannie Deak	
Michael Rutkin	Toms River Surgery Center
Stephen Felton, MD	
Ed Steinman, MD	
Michael Wong, MD	
Nancy Wisniewski, RN	
Anice Bacsik, RN	
Wanda Moore, RN	
Michael L. Sidor, MD	
Larry Trenk	
Alan F. Kwon, MD	Helios
Rebecca Vitillo	
Wendy Condo, RN	
Daryl Wilson, Administrator	Sparta Medical Associates
Claudette Downs, Administrator	Short Hills Surgery Center
Karen Thompson	Raritan Valley Surgery Center
Mary Ann Dipili	Same Day Surgery Center of Central Jersey
Samantha Kennedy, RN	
Michael Graziano, CASC	
Trudy Holt	
Marc L. Reichman, Dir. Of Adm.	Patient Care Associates
	Meininger
Mary Anne Dahmen	Eltra, LLC
Ann Sariego	
Gail Carroll	
Steven Espinosa	
Bonnie Brady	
Sharon Gelardi	
Andrew Weiss	
Todd Leventhal	
Tom Scinas	
Rosa Cruz	
Louise Zappola	
Marti Potter	
Sarah Malaniak	
Boqing Chen	Center for Advanced Pain Mgmt. & Rehab.
Roesanne Ottaggio	Surgical Specialists at Princeton

Rebecca L. Cowley	
Pat Sollitto	
Anna Delaguila	
Jose Santiago	
Kyle Melissa Alvarez	The Center for Ambulatory Surgery
Gina Rodrigues	
Meijie Diskin	
Paula De Oliveira	
Elaine Tanzi	
Susan L. Gurwitz	
Chad Itzkovich	Synergy Anesthesia
Susan DeBard, MPA	Endoscopy Center of Monmouth County
Shanton Jeffrey, MD	
Richard Bianco, RN, BSN	Jasper Ambulatory Surgical Center
Dawn Spencer	
Karen Guccione	
Steve Barainyak, MBA	Centennial Surgery Center
Georgia Perentesis	
June Duchinsky	County Line Endoscopy & Surgical Center
Colleen A. Relay	Somerset Surgical Center
Meg Stegliano	Seashore Surgical Institute
Larry Pecora	
Bertha Krapukaitis	
Ruby Dutta	
Nancy Chureete	
Mary Baiship	
Sharon De Mato, RN, Administrator	Endo-SurgiCenter
John Spa	
Barbara Polin	
James F. Puliafico	
Mary Fraizer	
Kathy Egges	
Kathleen LaPoff	
Jennie Barreiw	
Janet Boldt	
Rosemary Carpedew	
Patricia Tracy	
Michele Toudo	
Nora Iacono	
Suzanne M. Silover	
Annette Jachni	
Sylvia G. Brown	
Eunice Wilkerson	
Margaret Bozylowski	
Zenna Wilson	
Constance Vincent	

Chayala Strictiner
Jean Volosin
Patrick M. Wash
Ern Wlash
Sheila Levinson
Susan Hmas
Marguerite Crociata
Shawn Siymore
Sharon M. Solau
Gail Triefh
Patricia Reck
Dorothy Bonilla
Nancy Amoia
Chris Pucco
Maria L. Yukuv
Joseph Panala
Eugene DeAlmeida
Ricardo Carneiro
Michael C. DiPiczza
Michael D. Feld
Lawrence J. Friih
Teresa Puccio
Jennifer Plushot-Schacf
Robert C. Berg
Elaine Turner
Philip A. Bauman, MD
Ryan Porcaro
Claude Goulding
Amelou Ivory, RN
Rosemarie Russo Esposito, RN
Thomas Chun, MD
Jenno Cho, MD
Michael Betsy, MD
Jonathan Lester, MD
Oscar Vazquez, MD
Randy Marrinan, MD
Cori MacRae
John Demais, MD
John Scheuch, MD
Steven Katz, MD
Alan Miller, MD
Steven Tennenbaum, MD
Roy D. Vingan, MD
Robert W. Doidge, MD
Leonid Gutman
Ira Esfomes, MD

Rajnik Raab, MD
Sandorfi Gedin
Ralph Napoli, MD
Irene Riolo
John J. Holland
Louis Aiello
Carmen Hall
William Hale
Amelia Oviedo
Susan V. Pennica
Kelly A. Koziol
Dianna Dertinger
Dorothy Beeks
Valerie Beeley
George S. Coyle
Diane Moore
George Babyak
Janet Eve Landis, RN
Mania P. DeVarona
Gloria Berges
Evangelina Matarredona
Armando Matarredona
Mary H. Cornell
Vicki Davis
Elsey Sarcia
Frank Lysich
Thelma Smith
Joan Huff
John F. Connell
Geraldine Gregory
Barbara Cheeks
Jennifer Falcone
Caralyne S. Bagley
Jamile Dragone
Genesis Carriof
Moses Walto
Julia E. Jones
Barbara Lewis
Deborah Bigg
Frank J. Mason
Kristi L. Alberts
Tucia Navitski
Maria Ketah
Thomas W. Gardiner
John Dixon, Jr.
Daniel O. Martinez

Marissa Mancine
Traimier Francis
Douglas Moore
Blanche Talley
Ruth Flanagan
Martha Cassell
Robert Michaels
Florence E. Barriera
Betsy L. Reid
Elisa H. Iuliano
Barbara Willis
Paul Willis
Mary Choden
Krzysztof Gurzdz
Laurine Deakle
Ken Bogor
Daniel O. Martinez
Joan Ohiedzinzki
Komatten S. Muthsemy
Frank Floyd
Joseph Gitchin
Linda Y. Smith
Evelyn Kiley
Sharon De Mato
Andrea Henee
Lisa Fedongyk
Debra K. Walhu
Susan Copz
Jonathan Weise
Aneli Fernandez
Demetronla Christins
Linda Redmond
Deborah Lahoud
Wendy Izurietz
Sukhwinder Sinovh
Sukhair Singh
Tamaea Purnell
Betty Wachura
Sam Wathobio
Margaret De Freitcus
Jose L. Barreiro
M. McCloud
Steven Shane
Havia R. Da Costa
Jan Marsh
Frances Fedonyak

Anny Rinalde
Lauren Lopez
Nancy E. Rinaldo, RN
Edward Novik, MD
Juana R. Deans
Margaret Waitikowick — Ambulatory Surgical Center of Somerset
Laura Mazar
Susan M. Thomas
Kathy Lamastro
Cheryl Hichmon
Karen L. Hollenback
Kathleen Hampton
Charlice Scott
Pamela Santau
Stephen Zhine
Charlotte Murphy
Vijaya Morthy
Sarah Richardson
Diane Casais
Rodolfo Flores, Jr.
Carol A. Rice
Kathy Dugan
Kathryn J. Bolka, RN
James A. Cusinaro
Janet Leger
Michelle Miller
Jeff Pan, MD
Amy Pena
Linda Essig
Linda Keymetian
Daniel Walzman, MD
Emily J. Stefanicha, MS, PA-C
Daphne Conde
Duncan B. Carpenter, MD FACS
David Estin, MD
Roy Vingan, MD FACS
Dr. Joseph Musso C.C.S.P.
Mark Mannigan, Attorney for Somerset Orthopedic Associates and Spine Surgery Associates
Paul P. Vessa, MD
Robert F. Heary, MD, President NJ State Spine Society
Saad B. Chaudhary, MD, MBA
Mark J. Ruoff, MD
Ira M. Goldstein, MD, FANS
Michael J. Vives, MD
Steven R. Antico, Attorney for Arno Fried, MD, FACS

Alexis Mule
Arlene Rodriguez
Chirag D. Gandhi, MD
Genevieve L. Muti
Michele Spagnuolo
Ty J. Olson, MD
Timothy Link, MD
Hooman Azmi, MD
Marc Arginteanu, MD
Kevin Yao, MD
James W. Dwyer, MD
Lawrence Downs, Esq., CEO and General Counsel, MSNJ
Bryan J. Massoud, MD
Jonathan H. Lustgarten, MD
Leah Thompson, Kimba Medical Supply, LLC
Michael Golowski
Christopher F. Costello, Esq.
E. Vicki Ariaus, Esq.
David J. Klinger, Esq.
Joan Van Raalte, DMD
Robert A. Cappuzzo, Esq. for Chasan, Leyner & Lamparello, PC
Shari A. Rivkind, Esq.
Michael P. Molnar, Counsel for Plymouth Rock Assurance
Chuck Leitgeb, VP, ICNJ
Francesca Amendola Esq.
Maria Annunziata Esq.
Christopher Carnelli Esq.
Sergio Carro Esq.
Deborah Cassella Esq.
Cynthia Celentano Esq.
Maria Daniskas Esq.
Joseph DeMarco Esq.
Karen Eisele-Grabowski Esq.
John Fannan Esq.
Patrick Foley Esq.
Lisa Ganzhorn Esq.
James Garrabrandt Esq.
Michael Hackett Esq.
Sylvia Hebron Esq.
Maureen Johnston Esq.
Kathleen Kincade Esq.
Margaret Knuetter Esq.
Phillip LaPorta Esq.
Andrea Lardiere Esq.
Scott Noonan Esq.
Barry Odell Esq.

Andrew Patriaco Esq.
Karen Reis Esq.
Jennifer Remington-Knodel Esq.
Scott Sproviero Esq.
Nanci Stokes Esq.
Richard Zimmerman Esq.
Nora Brodow Esq.

N.J.A.C. 11:3-4 Personal Injury Protection Benefits; Medical Protocols; Diagnostic Tests

N.J.A.C. 11:3-4.2

COMMENT: One commenter noted that the phrase "close of business" was not defined in the definition of "days" in N.J.A.C. 11:3-4.2 as proposed. The commenter suggested that this ambiguity be eliminated by substituting "7 pm" for "close of business." Another commenter asked when day one would start if the Decision Point Review (DPR) request was received after the close of business. Another commenter stated that if the Department did not want to define the timeframe of normal working hours, it should let companies publish their own business day timeframes. The commenter also suggested that the rule be amended upon adoption to clarify that calendar days also do not include what it termed, "accommodation days": Black Friday; inclement weather closures, snow emergencies, or mandatory evacuation days in addition to Saturdays, Sundays, or legal holidays. Another commenter recommended basing all timeframes on business days. The commenter believed that using calendar days would adversely affect decision making timeframes especially when holidays are included with weekends.

RESPONSE: The Department agrees in part with the commenters. Unfortunately, some providers attempt to manipulate the system and get their DPR requests deemed approved

by submitting them at times that give the insurers the shortest review time possible. To address this issue for submission of DPR requests and appeals, the Department included a definition of "days" in the proposed amendments. The Department agrees that not having a specific time for "close of business" might provide additional opportunities for abuse and confusion. The Department believes that the best method to address the issue of defining "close of business" is to require insurers and their vendors to set a close of business time in their DPR plan and has proposed amending the rule upon adoption to so provide. The Department does not agree that the rule should be amended upon adoption to remove "accommodation days" from calendar days. These types of issues and how days are computed if a DPR request is received after the close of business are best addressed in the insurer's DPR plan. Concerning days when business cannot be transacted because of unpredictable occurrences such as inclement weather, insurers and their vendors should take advantage of the methods of electronic communication and include in their DPR plans instructions on how this information will be communicated such as by posting it on a website or providing automatic e-mail notifications. Finally, the Department does not agree that all days should be business days because it is more difficult to calculate longer periods of time by business days. For that reason, the Department believes that calendar days should be used for longer time periods.

N.J.A.C. 11:3-4.4

COMMENT: Many commenters expressed concern with the proposed amendments to N.J.A.C. 11:3-4.4 that would add a workers' compensation managed care organization (WCMCO) to organized delivery systems (ODS) as entities that provide physician networks to insurers. Insurers are permitted by the rule to waive deductibles and

copayments when insureds treat with a provider in these networks. One commenter believed that the proposed changes are "excessive, irrational, and detrimental" to all consumers who purchase automobile insurance in this State. Several commenters emphatically objected to a network organization in any form that would result in reduced or further discounted fees to physicians treating Personal Injury Protection (PIP) patients and indicated that unless the Department can specifically articulate reasons why WCMCO and ODS structures should be established and how they will improve the PIP program, the WCMCO structure should be excluded and the Department should reconsider its decision to include ODSs.

Several commenters expressed concern with the expansion of the ODS regulations and asserted that their broad "network" definition will not work to achieve the Department's goal to target abusers of the PIP system and thereby reduce costs in the system overall. Rather, they argued that the proposed amendments will unfairly penalize non-abusers and create a potential bar for patients to access providers who are not abusers of the system. Additionally, they stated that the expansion of the definition creates confusion regarding competing and conflicting requirements among the network contract, PIP statutes and rules regarding timeframes for precertification claims, care paths and treatment policies, and utilization management criteria and prompt payment of claims, etc. Several commenters believed that it would be inappropriate to compare a workers' compensation network to a PIP network either clinically or financially. The commenters asserted that the financial and payment structures of the two networks are entirely different; and unlike workers' compensation cases, there is no judicial review from a worker's compensation judge in the event a WCMCO provider prematurely discontinues or denies needed

medical treatment.

One commenter also noted that cost containment by the WCMCO will be a conflict of interest for the provider when the carrier who sent him the client is saying no further treatment is necessary. Several commenters suggested that the Department is exceeding its statutory authority to waive deductibles and copayments. Several commenters expressed opposition to this proposed amendment by characterizing it as de facto managed care for PIP patients via ODSs and WCMCOs. To the extent that care needs to be managed, the DPR process and utilization review contain elements of a managed care process.

Several commenters expressed their opinion that it is clear that the intent of the proposal is to force more providers into insurance networks, by creating strong disincentives to receive services from out-of-network providers. They assert that this will neither reduce nor prevent fraud. While the provider community has repeatedly heard the argument that requirements for cost-sharing via deductibles and copayments are valuable and necessary tools to control utilization, the proposal will legitimatize the waiving of copayments and deductibles, contradicting the previously touted arguments. Conversely, providers are prohibited from offering such waivers. The commenters expressed concern about "silent PPOs" and noted that the parameters of workers compensation networks are substantially different from the PIP system.

One commenter noted that while the Department has established very stringent requirements for ODSs, he is unaware of similar requirements for the providers in a WCMCO. Several commenters noted that the missions of both entities are statutorily

different: the WCMCO allows a contracting party to manage utilization of care and select the provider of medical service, while an ODS provides the networks of professionals for a carrier to access. The commenters further noted that the process of treating workers compensation injuries is drastically different than the process of treating automobile injuries. The provider assumes a significant array of risks in PIP cases (no coverage, exhausted benefits, medical necessity questions, delay of payment, etc.) that is not present in workers compensation treatment.

Several commenters urged that physicians need to be offered the opportunity to opt out of providing treatment for PIP patients under the terms of various commercial insurance plans or physicians will stop treating PIP patients when the new networks predominate in the market. Tying arrangements, in which a provider has no choice but to participate in all aspects of the managed care program agreement, are the standard occurrence at present and should not be permitted. Similarly, many commenters opined that there is a strong probability that the inclusion of WCMCOs for PIP use could result in a severe limitation on providers willing to treat patients.

One commenter stated that generally, treatment in workers' compensation cases is inadequate, ineffective and the patients are treated hastily by their doctors. Several commenters also noted that the majority of workers compensation networks do not allow chiropractors to participate in review panels, treatment protocols, or review of utilization guidelines, nor do they authorize chiropractic care. These commenters sought reconsideration of this exclusion and one noted in particular that modern mainstream medicine does not concentrate on manual therapy techniques, such as massage therapy and chiropractic manipulation to address the underlying cause of injury. Several

commenters noted concern with the inclusion of WCMCOs to treat auto accident victims and to waive copayments and deductibles. While this may seem like a great way to stretch the $250,000 PIP protection cap, WCMCOs will have access fees as well. The commenters queried: if patients are not satisfied with the WCMCO treating them, will they be able to leave the system and go elsewhere; will their access fee be refunded and will they have to pay copays and deductibles in the new system? If the patient opts to use a WCMCO network and the treatment is not appropriate and the patient does not recover, the commenters averred that there will be no ability to seek arbitration. The commenters stated that the bottom line is that the WCMCOs are another restriction on the kind of care a motor vehicle accident victim receives. The commenters asserted that it should not be the decision of any insurance company whether or not physical therapy or chiropractor visits should be reimbursed. They stated further that these proposed rules help insurance companies and limit consumers' access to the benefits they paid for when they purchased no-fault insurance and prey on financially challenged patients. The very purpose of the proposed comprehensive rules was to standardize practices and procedures and bring more certainty to the PIP program. The commenter believe that introduction of WCMCOs will do the opposite.

Several commenters stated that there is no concrete evidence that such a provision would enhance care, reduce costs, and be successful. Other states have attempted to introduce such a provision and have not been successful; instead, policyholders saw a rise in their premiums because many providers opted out of the "managed care" system. One commenter questioned, if a workers' compensation panel is used, whether chiropractors will be allowed to participate. If not, the commenter believed it would result in a restraint

of trade and limit on choice to the consumer. The commenter also questioned whether these issues will be explained to the consumer when they are deciding which policy to purchase.

RESPONSE: The Department notes that in adding WCMCOs in the proposed amendments to N.J.A.C. 11:3-4.4, it had no intention of incorporating the limitations on treatment, appeals or providers contained in the workers' compensation coverage in PIP and the text of the amendments does not do so. As such, the commenters' concerns about the quality of treatment in the workers' compensation system is outside the scope of the proposal. Similarly, comments about the process outlined in N.J.A.C. 11:3-4.4, whereby insurers can waive deductibles and copayments when insureds choose to be treated by providers in an ODS network, are outside the scope of the proposal because those rules have been in effect since 2010. See 42 N.J.R. 1385(a). However, because of the continuing confusion about the process, the questions and issues raised by the commenters, and the fact that no insurers have filed policy language to follow the process permitted by N.J.A.C. 11:3-4.4, the Department in its notice of proposed substantial changes proposed not to adopt the proposed amendments that would add WCMCOs to ODSs as network providers in addition to an ODS for this provision.

COMMENT: Several commenters supported the Department's decision to include WCMCOs in addition to ODSs as providers of networks for the voluntary program to waive the insured's deductibles and copayments for seeing providers in an insurer's network pursuant to N.J.A.C. 11:3-4.4(d). One commenter believed that the additions of WCMCOs to N.J.A.C. 11:3-4.4(d) would increase insureds' access to treatment and further the Department's goals to contain costs. Another commenter requested that the

Department repeal the requirement that the vendor access fees are only chargeable to the liability limits of the policy only when they are in excess of $10,000 in N.J.A.C. 11:3-4.4(d)2. The commenter recommended that all access fees be chargeable to the liability limits of the policy.

RESPONSE: The Department appreciates the support but, as noted above in the Response to a previous Comment, the Department has determined that the addition of the WCMCOs to N.J.A.C. 11:3-4.4(d) creates confusion and to date has not been utilized. The Department has determined not to adopt the proposed language. The commenter's request to repeal N.J.A.C. 11:3-4.4(d)2 concerning inclusion of access fee in policy limits would be a substantive change requiring additional notice and public comment.

N.J.A.C. 11:3-4.9

COMMENT: One commenter noted that N.J.S.A. 39:6A-4 permits benefits to be assigned to a "Provider of Service Benefits" and recommended that the Department use the statutory language in N.J.A.C. 11:3-4.9(a) instead of limiting assignment to a provider of "medical expense benefits."

RESPONSE: The Department agrees with the commenter that the statutory language is more precise and should be used in this subsection. The Department is amending the rule upon adoption to change "Provider of Medical Expense Benefits" to "Provider of Service Benefits."

COMMENT: One commenter noted that the Department had proposed N.J.A.C. 11:3-4.9(a)3 for repeal. The subsection permitted insurers to include a requirement in their DPR plans that required providers to submit disputes to alternate dispute resolution. The

commenter believed that the deletion of this wording could lead to the circumvention of the arbitration process. The commenter recommended that the language be reinstated.

RESPONSE: The Department agrees with the commenter. N.J.A.C. 11:3-4.9(a)3 was proposed for deletion in error. The Department proposed to and is amending the rule upon adoption to reinstate it.

N.J.A.C. 11:3-5 Personal Injury Protection Dispute Resolution

N.J.A.C. 11:3-5.6

COMMENT: Several commenters stated that N.J.A.C. 11:3-5.6(f) stayed the time for payment of an award pending a Superior Court review, but failed to include a similar stay for the clarification/modification and appeals processes. The commenters suggested that the rule be amended upon adoption to stay the award payment until conclusion of all the post-decision actions.

RESPONSE: The Department agrees with the commenters that N.J.A.C. 11:3-5.6(f) should stay payment for applications made for clarification/modification and appeals under Forthright's PIP arbitration rules, in addition to actions filed in the Superior Court and the rule is being amended upon adoption to so provide.

N.JA.C. 11:3-5.12

COMMENT: Several commenters noted that proposed N.J.A.C. 11:3-5.12(f) will implement a post-employment restriction on Dispute Resolution Professionals (DRPs) whereby DRPs shall not appear before any dispute resolution professional representing claimants or respondents. Commenters assert that this provision violates the New Jersey

State Constitution, which provides that the admission to and practice of law is within the sole and exclusive jurisdiction of the State Supreme Court. The commenters also note that the Supreme Court has placed restrictions upon former jurists when it has found such is necessary and appropriate, such as Directive #5-08 that prohibits judges who retire under the Judicial Retirement System Act, N.J.S.A. 43:6A-1 et seq., from appearing as an attorney in any contested matter in the courts of this State.

Additionally, citing *In re Supreme Court Advisory Committee on Professional Ethics Opinion No. 697*, 188 *N.J.* 529 (2009), the commenters assert that the "appearance of impropriety standard" cited by the Department as justification for the DRP post-employment restriction has been expressly rejected by the Supreme Court with regard to attorney discipline. The commenters imply that the Department's reliance upon N.J.S.A. 39:6A-5.1(b) is faulty. That statute provides that the "Commissioner shall establish standards of performance for the organization to ensure the independence and fairness of the [PIP dispute resolution] review process, including, but not limited to . . . standards to ensure that no conflict of interest exists which would prevent the [DRP] from performing his duties in an impartial manner." The commenters assert that the proposed regulation assumes that a conflict exists or that there is an appearance of impropriety in the appearance of a former DRP at a hearing in a PIP arbitration, and fails to include the Supreme Court's analysis in *In re Opinion No. 415*, 81 *N.J.* 318, 324 (1979), which directs that an evaluation of whether an appearance of impropriety exists cannot be in a vacuum, and requires a reasonable basis and something more than a fanciful possibility. The commenters also stated that attorneys who serve as municipal court judges have no presumed conflicts or restrictions imposed upon them by the Supreme Court, and any

perceived conflicts must be addressed on a case-by-case basis. Furthermore, relying on *In the Matter of Tenure Hearing of Onorevole*, 103 *N.J.* 548 (1986), the commenters argue that the Supreme Court has rejected the notion that an appearance of impropriety exists simply because a former "referee" takes the field as a "combatant." In that case, the Supreme Court held that a former Administrative Law Judge (ALJ) at the Office of Administrative Law (OAL) could appear at the OAL when there was no actual conflict or an appearance of impropriety. The commenters assert that the Department's role in PIP arbitrations is even more remote than the OAL's governance of its attorney appearance rules because the administration of PIP arbitrations has been vested with an outside dispute resolution organization (DRO) and the Department is not a quasi-judicial body.

The commenters also note that N.J.S.A. 39:6A-5.1, N.J.A.C. 11:3-5.5 and 5.12, and New Jersey No-Fault PIP Arbitration Rule 11 all mandate that DRPs avoid creating conflicts of interest as well as being required to complete and file a conflict of interest questionnaire. Specifically, N.J.A.C. 11:3-5.5(b)1 currently provides that "[n]o person shall serve as a DRP in any arbitration in which that person has any financial or personal interest. A DRP shall disclose any circumstances likely to create an appearance of bias, which might disqualify him or her as a DRP." Further, the commenters highlight that this obligation is continuous, and also flows to the DRO, Forthright Solutions, and once a potential conflict is revealed the DRO has an obligation to address the conflict or remove the DRP.

The commenters assert that the Supreme Court has already addressed the Department's concern in the Rules of Professional Conduct (RPC) governing attorneys, where RPC 1.12(c) provides that a "lawyer shall not negotiate for employment with any person who

is involved as a party or as an attorney for a party in a matter in which the lawyer is participating personally and substantially as a judge or other adjudicative officer, arbitrator, mediator, or other third-party neutral."

Lastly, the commenters assert that their status as independent contractors without benefits make the Department's proposed regulation an impermissible restrictive covenant, and risks the DRPs' status as independent contractors. Specifically, the commenters assert that the post-employment restriction in the proposed regulation rises to the level of an undue hardship upon the DRPs because they would be unable to find other employment in their area of expertise for one year. Moreover, the commenters argued that restrictive covenants in the legal profession have been addressed unfavorably, and that Disciplinary Rule 2-108(A) of the American Bar Association provides that lawyers shall not be a party to a partnership/employment agreement that restricts the right of the lawyer to practice law after the termination of a relationship created by the agreement.

RESPONSE: The Department agrees in part with the commenters and recognizes the Supreme Court's exclusive jurisdiction over attorney discipline as noted by the commenters. However, N.J.S.A. 39:6A-5.1.b provides that the Commissioner shall promulgate rules and regulations for the conduct of PIP arbitrations and "shall establish standards of performance for the organization to ensure the independence and fairness of the [PIP dispute resolution] review process, including, but not limited to, standards relative to the professional qualifications of the professionals presiding over the dispute resolution process, and standards to ensure that no conflict of interest exists which would prevent the [DRP] from performing his duties in an impartial manner." This statute expressly directs the Department to ensure the independence and fairness of PIP

arbitrations and to establish processes and rules to eliminate conflicts of interest from presiding DRPs. Therefore, the Department believes it is well within its scope of authority to ensure that DRPs acting as neutral arbitrators do not solicit or negotiate for employment with any parties or attorneys appearing before them. As stated in the proposal, when DRPs go directly from hearing cases as neutral arbitrators to appearing as advocates for parties who appeared before them it creates an appearance of impropriety, and impugns the impartiality of the decisions issued by the DRPs prior to the employment change.

Nevertheless, N.J.A.C. 11:3-5.5 provides that DRPs must be either: attorneys licensed to practice in New Jersey with at least 10 years of experience in personal injury or workers' compensation; former judges of the Superior Court or Workers' Compensation Court or a former ALJ; or any other person, qualified by education and at least 10 years' experience, with sufficient understanding of automobile insurance claims and practices, contract law, and judicial or alternate dispute resolution practices and procedures. As such, the Department acknowledges that the majority of DRPs fall into the attorney category, and are subject to the Rules of Professional Conduct generally, and the specific post-employment restriction and non-solicitation provision applicable to arbitrators in RPC 1.12. In RPC 1.12(a), the Supreme Court has provided that "a lawyer shall not represent anyone in connection with a matter in which the lawyer participated personally and substantially as a judge or other adjudicative officer, arbitrator, mediator or other third-party neutral . . . unless all parties to the proceeding have given consent, confirmed in writing." Additionally, RPC 1.12(c) provides that "[a] lawyer shall not negotiate for employment with any person who is involved as a party or as an attorney for a party in a

matter in which the lawyer is participating personally and substantially as a judge or other adjudicative officer, arbitrator, mediator, or other third-party neutral."

In totality, these provisions in RPC 1.12 directly prohibit the specific conduct that is at the heart of the Department's proposed new rule. The Department also believes that the conduct prohibited by RPC 1.12 would also fall under the conflict of interest provisions currently in the Department's regulations at N.J.A.C. 11:3-5.12(a) through (d). Therefore, the Department has determined that the new regulation in N.J.A.C. 11:3- 5.12(f) is unnecessary and, as was proposed in the Notice of Proposed Substantial Changes, the provision is being deleted upon adoption.

N.J.A.C. 11:3-29 Medical Fee Schedules: Automobile Insurance Personal Injury Protection Coverage

N.J.A.C. 11:3-29.2

COMMENT: Several commenters suggested that the Department amend the definition of "outpatient surgical facility" to remove doctors' offices from the definition. The commenters believe that doctors who perform minor surgical procedures in their offices do not need to receive a facility payment in addition to the physicians' fee for the service itself. The commenters also suggested that the existence of a facility fee for services performed in a doctor's office would encourage some providers to perform minor surgical procedures for which they do not have the proper equipment or facility, thus endangering patient safety. Another commenter suggested adding the following language to the definition, "a doctor's office where ambulatory surgical cases are performed and where the provider has obtained proper certification requirements which allow services to

be performed in an office setting." Another commenter asked what licensure or certification, if any, a doctor's office must hold to meet the definition of an OSF. Another commenter suggested requiring providers to use the modifier -SF when billing for services that are performed in an office setting. The commenter believed that such a modifier would distinguish facility services from professional services. The commenter recommended that the provider only be able to bill for a facility fee if the provider has a "surgical suite." The commenter stated that it was concerned with providers billing a facility fee for procedures being performed in a doctor's office that do not require the use of a surgical suite. The commenter believed that a provider should only be reimbursed for their professional fee in such cases.

RESPONSE: The Department agrees with the commenters. As part of the proposed amendments discussed below concerning the establishment of a separate Hospital Outpatient Surgical Facility (HOSF) Fee Schedule, in the notice of proposed substantial changes the Department proposed to delete the definition of "outpatient surgical facility or OSF," which includes the "doctor's office" language referenced by the commenters, and is making that change upon adoption. The Department notes that the definition of Ambulatory Surgical Center (ASC) already included a physician-owned single operating room in an office setting that is certified by Medicare. The Department believes those are the only types of doctors' offices that can receive facility fees.

N.J.A.C. 11:3-29.4

COMMENT: One commenter noted that N.J.A.C. 11:3-29.4(g)6 as proposed stated that supplies for TENS and EMS units are included for rentals and purchases of the devices.

The commenter said that the provision as it applies to a monthly rental is understandable but when talking about a purchase, the unit comes with a month of supplies, and when you continue to use the unit, additional supplies are needed. It does not make sense to try to determine a price amount when you do not know how long the unit will be used. Another commenter asked for confirmation that replacement TENS leads, batteries, etc. are not reimbursable.

RESPONSE: The Department agrees with the commenters that supplies for TENS and EMS units should only be included in the rental, not the purchase fee. The Department proposed to amend N.J.A.C. 11:3-29.4(g)6 in the notice of proposed substantial changes to delete the reference to purchase and is making that change upon adoption. Moreover, the codes and fees for these supplies are already in Appendix, Exhibit 5.

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

COMMENT: Several commenters expressed concern that the OSF fee schedule would cause patients to be admitted to hospitals for procedures that are appropriately performed in outpatient facilities. It was asserted that such hospital stays would lead to higher costs for care to the detriment of injured persons whose policy limits will be exhausted. Another commenter stated that by defining "OSF" to include a hospital outpatient department, DOBI is inexplicably applying the Medicare ASC coverage standards to procedures performed in a hospital outpatient department (HOPD). The Medicare ASC coverage standards were plainly intended to apply only to ASCs; Centers for Medicare and Medicaid Services (CMS) utilizes separate standards to determine coverage of services performed in HOPDs. In applying the Medicare ASC coverage standard to

HOPDs, DOBI is prohibiting the performance of outpatient procedures in an HOPD under PIP that are clearly covered under Medicare when performed in an HOPD. Finally, another commenter noted that decompression of spinal cord or nerve root thoracic are not listed on the proposed outpatient facility fee schedule.

RESPONSE: The Department agrees with the commenters that the restrictions on the procedures that can be performed in an ASC are not appropriate for an HOSF. As noted in the notice of proposed substantial changes upon adoption and in a Response to another Comment, the Department has determined that it is necessary to propose a separate hospital outpatient surgical facility fee schedule that would, consistent with Medicare rules, permit certain procedures to be performed in hospital outpatient facilities that cannot be performed safely in an ASC and is making that change upon adoption.

COMMENT: One commenter stated that CMS's determination with respect to the coverage of ASC procedures under Medicare should have no bearing on the PIP fee schedule. CMS specifically stated that its Medicare ASC coverage standards apply only to determine whether they are appropriate for Medicare beneficiaries in ASCs. Additionally, the commenter noted that the application of Medicare ASC coverage standards to the PIP fee schedule usurps physician's medical decision-making. A number of commenters submitted a form letter which stated that the limitations on the procedures that can be performed in an ASC deprives consumers of the ability to choose the most cost-effective and efficient setting for their treatment. The commenters asserted that this change will increase rather than decrease the cost of PIP benefits. The commenters believed that consumers should retain the ability to have procedures performed wherever they choose, by healthcare providers of their choice, regardless of the network

participation, and without fear of a financial penalty.

RESPONSE: The Department does not agree with the commenters. The Department believes that there must be a definition of what services can be performed safely in an ASC and are therefore reimbursable under PIP. The Medicare definition is designed to ensure that the facility is operated in a manner that ensures the safety of patients and the quality of services. Medicare has determined that a procedure that meets any of the criteria below cannot be performed in an ASC:

1. Poses a significant safety risk to the patient;

2. Typically requires active medical monitoring and care at midnight following the procedure;

3. Is on the inpatient only list;

4. Directly involves major blood vessels;

5. Requires major or prolonged invasion of body cavities;

6. Generally results in extensive blood loss;

7. Is emergent in nature;

8. Is life-threatening in nature;

9. Commonly requires systemic thrombolytic therapy; or

10. Can only be reported using an unlisted surgical procedure code.

"Medicare Program; Revised Payment System Policies for Services Furnished in

Ambulatory Surgical Centers (ASCs) Beginning in CY 2008; Final Rule," Federal Register 72 (August 2, 2007): 42483.

The Department also does not agree that the determination whether to perform a procedure in an ASC or a hospital outpatient or inpatient facility usurps a physician's medical decision-making. On the contrary, since many physicians have a financial interest in ASCs, the decision about where to perform the procedure may be influenced by financial factors. In addition, the proposed changes have nothing to do with networks or financial penalties. Overall, the limitation on the services that are reimbursable if performed in an ASC is based on patient safety, not on restricting patient choice or on the cost of the procedure. Therefore, it is reasonable and appropriate for the Department to rely upon the expertise and experience of CMS in this regard. Additionally, the Appellate Division has already recognized that the Commissioner has authority under the PIP statutes to impose some limits on an individual's choice in selecting providers and vendors. *Coalition for Quality Health Care v. NJ Dep't of Banking and Ins.*, 348 *N.J. Super.* 272, 309 (App. Div. 2002) ("*Coalition II*"),

COMMENT: Several commenters expressed concern with including hospital outpatient care in the OSF Fee Schedule and noted that the proposal would result in PIP being the first and only insurer that will pay New Jersey hospitals the same amount for outpatient surgical procedures as is paid to freestanding ASCs. Under the Medicare system, which acknowledges that ASCs have lower costs than hospitals associated with providing identical services, hospitals receive significantly higher payments than freestanding ASCs for the same outpatient surgical procedures. One commenter expressed serious concern with the Department's methodology for determining hospital outpatient fees. While

setting the amount of the facility fees at 300 percent of the 2011 ASC Medicare base rate and wage index appears fair for an ASC, it ignores the fact that Medicare pays hospitals a differential above the ASC rate to adjust for the higher costs of providing care in a hospital, including the provision of services to Charity Care and Medicaid patients. Paying a similar differential under PIP is even more critical; without it, hospitals across the State would be bankrupt. The commenter recommended that if the Department will not exempt all hospital claims, then at a minimum it should include hospital rate differential payments similar to the Medicare rate under the PIP Outpatient Fee Schedule.

RESPONSE: The Department agrees with the commenters that it is not appropriate to pay hospital outpatient facilities the same facility fee amounts as ASCs are paid based on the differences in Medicare's cost-based reimbursements to these facilities. As described in detail in the Summary to the notice of proposed substantial changes, the Department proposed adding new Appendix, Exhibit 7 upon adoption to establish a separate fee schedule for HOSFs that recognizes the higher cost basis for such hospital facilities according to the data on which the Medicare reimbursement rates are based. As with the similar facility fees for ASCs, the Department has determined to set the HOSF fees in new Exhibit 7 at 300 percent of the 2011 geographically wage-adjusted Medicare Hospital Outpatient Department fees for Bergen County (North Region) and Atlantic County (South Region). The Department proposed to amend Appendix, Exhibit 1 to change the heading of the "Physicians' & Outpatient Facility Fee Schedule" back to "Physicians' & Ambulatory Surgical Center Facility Fee Schedule" and to make other changes to the rules necessary to have the rules provide for both ASCs and HOSFs and is making those changes upon adoption.

N.J.A.C. 11:3-29.5

COMMENT: Several commenters noted that the proposed rule for OSF fees at N.J.A.C. 11:3-29.5(b)2 states that implantable devices are not included in the facility fees but are billed at invoice plus 20 percent. The commenter stated that in many cases the Medicare Ambulatory Payment Classification (APC) rates used in setting the OSF facility fees include the implantable device and to allow the device to be billed and paid for separately would result in insurers paying many times for the cost of the implantable device. One commenter provided the example of Current Procedural Terminology (CPT) code 63685. On the OSF fee schedule for the Northern region that code has a rate of $47,572.08. The commenter notes that the corresponding Medicare fee for the code is $14,743.58, of which $12,634.45 is the cost of the implant and $2,109.13 is the cost of performing the procedure. Under the proposal, not only would the facility receive 300 percent of the cost of the device built into the facility fee, but the facility could separately bill for the device again, and thus be reimbursed many times the actual cost for such implant devices.

RESPONSE: The Department agrees with the commenters that for ASCs and HOSFs, the devices are included in the facility fee and that for device-intensive procedures such as CPT 63685, the proposed fee would result in the ASC receiving many times the actual cost of the device. Thus, in the Notice of Proposed Substantial Changes the Department proposed to delete N.J.A.C. 11:3- 29.5(b)2 upon adoption (now N.J.A.C. 11:3-29.5(c)2 because of the addition of new subsection (b) and is making that change upon adoption) As noted above in the Response to another Comment, upon adoption the Department is also adding a new HOSF fee schedule and amending the Physicians' Fee Schedule, which includes facility fees for ASCs. The fees on the new and amended schedules are set at

300 percent of Medicare as initially proposed, except that they have been adjusted to include only 120 percent of the cost of the device. So, for example, 300 percent of the Medicare ASC fee for CPT 63685 was on the initially proposed OSF fee schedule for $47,572 but that included a device that costs $12,623. Charging only 120 percent for the cost of the device lowers the fee for this service to the correct amount of $24,643.

N.J.A.C. 11:3-29 Appendix, Exhibit 1

COMMENT: One commenter noted that CPT 95805 is listed on the Physicians' Fee Schedule with a global and a technical fee but no professional fee. Another commenter noted that one of the CPT codes for EEGs, 95812, only has a global fee, not the technical or professional component fees that the other EEG CPT codes have. The commenter asked if this was intentional or an omission.

RESPONSE: CPT code 98505-26 had the 85 transposed in the fee schedule. Code 95805 is not on the fee schedule. Similarly, the 58 in the technical and professional modifiers of CPT code 98512 and the global fee for 98513 were transposed and appeared on the fee schedule as 95812 and 95813. The incorrect codes are proposed to be deleted and the correct codes are proposed to be added to the fee schedule upon adoption.

COMMENT: Several commenters stated that the proposed changes to the PIP fee schedule will be devastating to the delivery of high quality and complex spine care and strongly object to the inclusion of spine surgery CPT codes in the schedule and the resultant significant decreases in reimbursement. One commenter identified the most common CPT codes and procedures performed by spine surgeons and provided a comparison between the proposed PIP schedule and what actual, regular healthcare

insurers provide. Another commenter submitted a chart comparing proposed PIP fee schedule reimbursement with what healthcare insurers actually reimbursed for various spinal surgeries, substantiated by explanations of benefits (EOBs) and checks paid to the practice. The commenter noted that drastic reductions in the present compensation for these procedures would make it very difficult to continue to provide this technical and specialized care to motor vehicle accident (MVA) patients.

The commenters noted that there is a significant shortage of spine surgeons in New Jersey and that reimbursements for covered trauma cases by spine surgeons will be decreased by greater than 50 percent. The commenters noted that this could lead to the unintended consequence that spine surgeons may opt to no longer cover emergencies and be on-call at multiple hospitals, or would cover only the minimum required by Federal law because of the higher medical malpractice liability associated with these cases, the need to cancel office hours and/or elective cases in order to provide care for MVA victims, and the significantly reduced reimbursement rates. This could result in patients being transferred from hospitals which do not have emergency spine coverage to Level 1 trauma centers; these types of hospital transfers place the patient at undue risk, strain the resources at the receiving hospital, and create enormous inconvenience for patients transferred far from home and required to make return visits for follow-up care.

RESPONSE: Upon review of the comments received, the Department has determined that additional study of the physician fees for 117 CPT codes on the Physicians' Fee Schedule for spinal and neurosurgical procedures is required. As was noted in the proposal, the available data on the fees paid to providers for these low-frequency procedures is limited. As was referenced in the notice of proposed substantial changes,

the Department is removing the fees for these codes from the Physicians' Fee Schedule upon adoption until this issue can be studied further.

COMMENT: Several commenters wrote in strong opposition to the inclusion of major spinal surgery CPT codes in the proposed Medical Fee Schedule, and noted that the inclusion will make it increasingly more difficult for neurosurgeons to care for PIP patients and inhibit neurosurgeons from providing quality emergency room and trauma center care. Patients suffering head or spine trauma or strokes will have much less chance of regaining independence and returning to home or work, ultimately increasing the State's expenditures for their care. For several commenters, reimbursements from PIP and some private carriers essentially allow their practices to stay solvent. Several commenters noted that many neurosurgeons would cease to provide neurosurgical coverage in the trauma hospitals and some would leave the State altogether. Neurosurgeons pay the highest premiums for malpractice insurance and neurosurgical training is longer than any other specialty. Many emergency room cases are seen without reimbursement or are Medicaid or Medicare, which also reimburse poorly for surgeons, and these cases are the greatest source of legal liability. Tagging any fee schedule to Medicare is a mistake. Certain spinal procedures included in the Schedule are simply too complex and too risky to warrant a reduction in reimbursements. The proposed reduction of fees will likely involve changes in coverage in emergency rooms, and threaten participation in Medicare. Several commenters noted that a patient's entire PIP auto benefit may be consumed by pain management doctors before they even get to the spinal surgeon or neurosurgeon for definitive treatment.

RESPONSE: As noted above in the Response to another Comment, the Department is

deleting the physician fees for 117 spinal and neurosurgical codes upon adoption pending further study.

COMMENT: Several commenters noted that the use of spine surgical CPT codes by non-surgeons has driven up the costs of healthcare and suggested that once the claims of the non-surgeon population using the CPT codes are removed from the equation, there is no need to include the spine surgery CPT codes in the PIP fee schedule. An examination of the healthcare expenditures should be performed to determine how many PIP claims are being processed for non-surgical "procedures" versus how many actual surgical operations are being covered. The commenters also recommended examination of the distinction between acute care for trauma versus that given for persistent complaints or conditions created or exacerbated by a trauma. The commenters recommended that this analysis occur before a decision is made on changes to the PIP fee schedule for spine surgeries. Several commenters urged that if auto carriers are concerned about medical costs, then they should prevent non-surgeons from billing with surgical codes. Several commenters also inquired why the high profits of insurance companies are being protected at the cost of quality care for patients.

RESPONSE: As part of the review to be undertaken on the reimbursement of spinal and neurosurgical codes mentioned above in the Response to another Comment, the Department will also look into these concerns about providers who bill surgical codes for non-surgical treatment. As noted above, 117 spinal surgery codes will be deleted from the proposal upon adoption and in accordance with the notice of proposed substantial changes.

COMMENT: Several commenters expressed support for the addition of more fees to the fee schedule to provide certainty to PIP providers, but were concerned that certain specialties, such as neurosurgery and pain management, may have been unfairly targeted and their fees underestimated. These specialists are particularly important to patients who have been injured in car accidents. The unintended consequences of under-assessing fees may deter these specialists, already in short supply, from treating the PIP patient population.

RESPONSE: As noted above in the Responses to other Comments, the Department is deleting the physician fees for 117 spinal and neurosurgical codes from the Appendix, Exhibit 1 upon adoption and those physicians will be reimbursed at the usual, reasonable, and customary fee pursuant to N.J.A.C. 11:3-29.4(c).

COMMENT: One commenter asked for additional time to analyze the proposed changes for neurosurgery reimbursements to assist in determining a more optimal and equal solution than drastic and harmful across-the-board fee reimbursement reductions.

RESPONSE: As noted above in the Responses to other Comments, the Department is deleting the physician fees for 117 spinal and neurosurgical codes from the Appendix, Exhibit 1 upon adoption.

COMMENT: Several commenters stated that if major spinal surgery CPT codes are included in the Medical Fee Schedule, many neurosurgeons will reduce the size of their office support staff and their benefits because of the inadequate compensation in the Schedule. The impact on employees of these practices must also be considered.

RESPONSE: As noted above in the Responses to other Comments, the Department is

deleting the physician fees for 117 spinal and neurosurgical codes from the Appendix, Exhibit 1 upon adoption.

COMMENT: One commenter noted that CPT 98943, Chiropractic Manipulative Treatment, Extraspinal, was previously listed in the fee schedule with a reimbursement rate but it does not appear in the proposed fee schedule. However, the code is listed as being subject to the daily maximum. The commenter asked if the Department intended to omit the code from Exhibit 1.

RESPONSE: The Department inadvertently omitted the code for extraspinal manipulation from the fee schedule. As noted above in the Response to a previous Comment, and in the Notice of Proposed Substantial Changes, the Department is amending Appendix, Exhibit 1 upon adoption, which amendments will include adding a fee for 98943.

N.J.A.C. 11:3-29 Appendix Exhibit 2

COMMENT: One commenter pointed out that codes D7880 on the Dental Fee Schedule and codes CPT 21085 and 21110 on the Physicians' Fee Schedule describe very similar services but have different fees. This creates disputes about which code to use. The commenter recommended setting the codes on the dental fee schedule at the same fee as CPT 21110 on the Physicians' Fee Schedule.

RESPONSE: The Department agrees with the commenter. In the notice of proposed substantial changes it proposed to amend Appendix, Exhibit 1 to make the fee for CPT 21085 the same as CPT 21110 and upon adoption is amending Appendix, Exhibit 2 to make that change and the fee for D7880 the same as the fee for CPT 21110 on the

Physicians' Fee Schedule. In addition, as was set forth in the notice of proposed substantial changes, the Department notes that the code D0210, Intraoral, complete series, was inadvertently omitted from proposed Appendix, Exhibit 2, the Dental Fee Schedule, and a fee for the service is being added upon adoption.

2. Comments Received During Initial Comment Period, Not Giving Rise to Changes in the Rule Proposal

The Department received more than 18,000 comments on the initial notice of proposal, which did not themselves give rise to changes upon adoption. A list of the names of all of the commenters on that notice has been filed with the Office of Administrative Law. Pursuant to N.J.S.A. 52:14B-7(c) and N.J.A.C. 1:30-5.2(a)2, the names of these commenters are not published herein, but may be reviewed by contacting the Office of Administrative Law, 9 Quakerbridge Plaza, Building 9, PO Box 049, Trenton, New Jersey 08625-0049.

COMMENT: The Department received 15,487 form letters from commenters expressing support for the proposal. Of these, 15,432 stated their support without further elaboration and 55 others based their support on the commenters' belief that the proposal will serve the interests of New Jersey auto insurance consumers by reforming many rules that force auto insurers, in many instances, to pay grossly inflated medical charges. These comments further noted that the proposal addresses an issue that was not included when bipartisan auto insurance reform was enacted in 2003.

RESPONSE: The Department thanks the commenters for their support of the proposal and agrees that it reforms rules that in some instances previously required insurers to

reimburse excessive fees charged by certain PIP providers. The 2003 legislation mentioned by the commenters was focused on insurer rating and underwriting issues. The Department's authority for the current proposal is found in the Automobile Insurance Cost Reduction Act of 1990.

COMMENT: The Department received four form letters from commenters expressing support for the proposal and requesting the Department do everything possible to "discontinue the exorbitant counsel fees that are paid to New Jersey attorneys by auto insurance companies in this State." The commenters stated that, as members of the legal community for many years, they could attest to New Jersey attorneys inflating their bills with the costs of their doing so "trickling down" to New Jersey insureds. The commenters expressed the hope that the Department will "rectify this unfair situation," noting that "New Jersey drivers have paid too much for auto insurance for far too long."

RESPONSE: The Department thanks the commenters for their support and believes the amendments to N.J.A.C. 11:3-5, the rules on PIP Dispute Resolution, will effectively address the commenters' concerns regarding excessive attorneys' fees paid in some PIP arbitrations.

COMMENT: The Department received 720 form letters from commenters stating that, while they recognized and supported the need for reform, the proposed rules are remiss in several key areas. These commenters noted that procedures routinely performed in ASCs are excluded from the proposal, which they asserted deprives consumers of the ability to choose the most cost effective and efficient setting for their treatment. The commenters asserted that, contrary to one of the primary stated reasons for the reform, this will

increase rather than decrease the cost of PIP benefits. The commenters believed that consumers should retain the ability to have procedures performed wherever they choose, by healthcare providers of their choice, regardless of network participation, and without fear of a financial penalty.

RESPONSE: The Department does not agree with the commenters. N.J.S.A. 39:6A-4.a provides that the Commissioner shall establish the benefits provided under PIP coverage for reasonable, necessary and appropriate medical treatments, diagnostic tests and services, as well as other benefits the policy may provide. Pursuant to N.J.S.A. 39:6A-4.6.a, the Commissioner also has the exclusive statutory authority to exercise his technical expertise to promulgate schedules of fees in a necessary regulation.

N.J.S.A. 39:6A-4.6.a provides the Commissioner with broad discretion to select those categories of fees or services which warrant inclusion in the regulation and it does not limit or compel the categories of services or locations in which such services must be available for reimbursement. The Department followed Medicare's determination of which procedures can appropriately be performed in ASCs because Medicare provides a sound and detailed analysis of procedures that can be safely performed in ASCs. Medicare excludes procedures that pose a significant risk to the patient. Procedures are excluded if they: (1) typically require active medical monitoring and care at midnight following the procedure; (2) are on the inpatient only list; (3) directly involve major blood vessels; (4) require major or prolonged invasion of body cavities; (5) generally result in extensive blood loss; (6) are emergent in nature; (7) are life-threatening in nature; (8) commonly require systemic thrombolytic therapy; or (9) can only be reported using an unlisted surgical procedure. Utilization of the Medicare determinations as to the

procedures that can be safely performed in an ASC is well within the Commissioner's statutory authority and expertise to determine appropriate treatments, and it is reasonable and medically sound. Moreover, the commenter has not provided any evidence that demonstrates that the limitations in the ASC facility fee schedule will increase the costs of PIP reimbursements.

COMMENT: The Department received 38 form letters from commenters opposing the proposal, asserting that it only serves the interest of New Jersey auto insurers, not those of the citizens of New Jersey. The commenters noted that arbitration is the only avenue available to claimants and their physicians when an insurer's doctor concludes the claimants do not need treatment. The commenters asserted that these doctors do a paper review, usually without being provided with all of the pertinent documents, and that termination of benefits should only be available when a claimant is examined in person by a physician. The commenters noted that insurance company employees are well compensated, and New Jersey insurers have been "posting profits and taking big bonuses." The commenters stated that such companies should not be allowed to cap more fees and expenses on the backs of policyholders who pay their excessive premiums.

RESPONSE: The Department does not agree with the commenters. N.J.S.A. 39:6A-5.1 provides that medical expense benefit disputes between an insured and an insurer may be submitted to PIP arbitration "on the initiative of any party to the dispute." Based upon this express statutory language, many auto insurance policies require the submission of all PIP medical treatment and reimbursement disputes to arbitration under N.J.A.C. 11:3-5. Moreover, the adopted rules only seek to impose a common-sense requirement that every effort be made to resolve such disputes prior to initiating the arbitration procedure

through the insurers' internal appeal processes. Although the Department has delayed the operative date of the new internal appeal rule and intends to amend the rule in the near future, the Department still believes that utilization of the appeals process is a reasonable and necessary cost containment measure. The Department does not understand the commenter's reference to solely paper reviews by doctors without all the necessary documents. Additional information can be submitted by the provider during the internal appeals process and the insurers can conduct medical examinations prior to making any decision. See N.J.A.C. 11:3-4.7 and 11:3-4.7B. Furthermore, medical necessity determinations during arbitrations can be submitted to a Medical Review Organization (MRO) at the behest of any party. See N.J.A.C. 11:3-5.6. Most insurers require patients to have in-person independent medical examinations (IMEs) before termination of treatment. The Department also does not agree with the commenter's apparent assertion that the Department should not increase the fees of most providers, address over-utilization and exploitation of loopholes, and preserve the PIP benefit for insureds because insurance companies are profitable. As noted in the notice of proposal, PIP costs continue to exert upward pressure on private passenger automobile (PPA) insurance rates and PIP coverage contributes to 97 percent of all rate increase requests in the past year. Thus, these new rules and amendments are necessary and well within the Commissioner's statutory authority under N.J.S.A. 17:33B-42, to implement any procedure or practice that he deems necessary to more effectively control the cost of providing PIP coverage to insureds in this State, including procedures or practices to increase the efficiency of insurers or to prevent fraudulent practices by the insured, insurers, providers of services or equipment, or others.

COMMENT: The Department received 158 form letters from commenters opposing the proposal noting that they fear the proposed amendments and new rules will further delay and deny medically necessary treatment to the economic benefit of insurers and to the detriment of consumers' health and well-being, particularly the internal appeals process, Medicare rates basis, and dispute resolution.

RESPONSE: The Department does not agree with the commenters. The Department believes that new and amended rules and the expanded fee schedules will enable the provision of timely and cost certain medical treatment under PIP. The increased number of CPT codes will reduce the need for insurers to conduct reviews of the Usual Customary and Reasonable fee for procedures that are not the Medical Fee Schedules. This will eliminate the need for many reimbursement arbitrations. Additionally, the Department believes that the internal appeal process, once effective, will eliminate delays in treatment because the process will be much faster than arbitration. As addressed below in response to other comments, the Department's use of Medicare was affirmed by the Appellate Division in *In re Adoption of N.J.A.C. 11:3-29 by the New Jersey Dep't of Banking and Ins.*, 410 *N.J. Super.* 6 (App. Div. 2009) ("*In re Adoption of N.J.A.C. 11:3-29*"), because the Resource Based Relative Value System (RBRVS) used by Medicare calculates the relative value of procedures taking into account the physician's work required, the practice expenses for the procedure and the malpractice premium associated with each CPT code, and it is the only transparent, comprehensive, resource-based source of medical fee information. Thus, the Department's continued reliance on Medicare is well-justified. Furthermore, the Department believes that the new "on-the-papers" appeal dispute resolution process will further speed the resolution of nominal PIP

reimbursements, in coordination with the already existent prompt MRO reviews of medical necessity issues and expedited and emergent reviews upon demonstration of immediate and irreparable loss. See N.J.A.C. 11:3-5.4(b)3 and 5.6.

COMMENT: The Department received 194 form letters from commenters opposing the proposed amendments. They noted having been involved in a motor vehicle accident in New Jersey, having found it difficult to locate medical providers willing to test and treat such persons and, once having done so, that their insurer made it very difficult for them to obtain the necessary treatment and testing and get their bills paid. The commenters stated that their carriers seemed more concerned with delaying and denying care and charges despite their having faithfully paid their premiums, and that the insurers' sole concern appeared to be increasing profits.

These commenters also feared that the proposal will further delay and deny medically necessary treatment to the economic benefit of the insurers and to the detriment of consumers' health and well-being, particularly the internal appeals process, Medicare rates basis, and dispute resolution.

RESPONSE: The Department does not agree with the commenters. The Department receives very few complaints from insureds who cannot locate providers who are willing to treat PIP patients. The Department does not believe that the generalized complaints about insurer conduct contained in what appear to be form comment letters provide a sufficient and reliable basis upon which to modify the adoption of the PIP amendments and new rules. The Department also investigates individual complaints against insurers and does Market Conduct examinations of insurers, which include reviews of claim

practices. The Department believes that the internal appeal process will significantly reduce delays in treatment because the process is much faster than arbitration. As addressed below in response to other comments, the Department's use of Medicare is not new, was affirmed by the Appellate Division, and is the only transparent, comprehensive, resource-based source of medical fee information.

COMMENT: One commenter stated that it is supportive of the Department's proposed PIP reform measures and commends the Department for recognizing troubling trends that affect all New Jersey drivers and for taking a proactive approach to address them.

The commenter stated that from its perspective as a national association that monitors the functioning of insurance markets in states across the country, the turnaround of the New Jersey auto insurance system since the passage of competitive reforms in 2003 has been a remarkable success story. However, these legislative reforms did not address aspects of the PIP system that tend to destabilize the long-term success of the competitive reforms.

The success of the 2003 legislative reforms can be attributed in large part to the role that the Department has played in overseeing a transition process to promote competition for the benefit of New Jersey drivers. With the PIP reform proposals, the Department continues to take a proactive stance to ensure that the state's auto insurance system serves the interests of New Jersey's insurance consumers.

The commenter observed that under the existing PIP system, auto insurers frequently pay inflated medical charges compared to what private health insurance and government programs would pay for the exact same services. The expanded medical fee schedule, adding about 1,100 procedures to the 1,500 procedures in the current fee schedule to

cover many common medical procedures, can be expected to reduce billing disputes, control costs and add predictability to the auto insurance system.

For cases where there are still disputes, the commenter noted that the Department is proposing to reform current arbitration rules, particularly regarding attorney fees. The proposal provides guidelines for the awarding of attorneys fees in an effort to ensure that awarded fees are commensurate with the amount in dispute and the amount awarded.

The commenter stated in conclusion that New Jersey has gone from having one of the most troubled auto insurance markets in the country to having one of the most vibrant, and the proposed PIP reforms are reasonable measures that will control cost and allow New Jersey drivers to continue to enjoy the benefits of competitive reforms.

RESPONSE: The Department appreciates the commenter's support and agrees that the adopted amendments will further cost-containment of PIP claims and will enable faster, more predictable resolution of disputes regarding the provision and reimbursement of medical benefits under PIP.

COMMENT: Several commenters commended the Department for proposing an expansion of the fee schedule to cover more services paid under PIP, thereby affording more predictability for auto insurers and providers with regard to PIP expenditures and payments and for its amendments to the alternate dispute resolution rule, including the mandatory uniform appeal process and the initial steps to address the disconnect between counsel fee awards and the amounts in dispute. Another commenter supported the rules proposed by the Department and stated that it believed that they represent the first step in what the commenter hopes will be a continuing common sense approach designed to

moderate the costs of the PIP system for insurers and consumers while preserving access to care. The commenter believed that further changes are needed, but did not elaborate on specific changes he believed were necessary. Another commenter wrote in support of the proposed rules and stated that the rulemaking will help to contain the cost of the medical expense benefit that private bus companies, unlike any other commercial vehicles, must provide.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter stated that it wholeheartedly supports the proposed rule and its intent. The commenter observed that PIP in New Jersey has become distorted and subject to abuse by a variety of economically motivated actors. The commenter believed that the proposal would fix systemic problems and strengthen PIP, which would benefit insurers and consumers. Another commenter noted that unnecessary administrative burdens and fee uncertainties do result in direct costs to practices, patients, and insurers, and supports the Department's efforts to update the schedule and add more codes. Another commenter stated that on the whole, the proposal will provide beneficial changes to the PIP system, which will positively impact insureds, medical providers and insurance carriers.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter supported the proposal and stated that when reviewing comments received on the proposed rule, the Department should consider where New Jersey's PIP benefits stand in comparison to other no-fault states. The commenter attached a copy of the statement it presented at the October 6, 2011 Assembly Financial

Institutions and Insurance Committee's informational hearing on the proposed rules. The commenter also attached a copy of a Property Casualty Insurers Association of America (PCI) Special Report entitled, "New Jersey's Broken Automobile No-Fault System: A Call for Reform" and requested that they be considered as part of its comment.

The October 6, 2011 Statement supported the regulations proposed by the Department and asserted that they are the first steps in what the organization hopes will be a common-sense approach designed to moderate the costs of the PIP system for insurers and consumers while preserving access and care. The Statement observed that it was important, in reviewing the proposal, that public policymakers consider where New Jersey's Personal Injury Protection Benefits System stands in relation to other no-fault states. In the Statement, the commenter stated that it had studied 12 other no-fault states and concluded that New Jersey motorists are still paying very high and, more importantly, rapidly rising PIP costs compared to motorists in other states. The Statement averred that drivers in New Jersey are seeing the value of their PIP coverage erode as consumer fraud, high medical costs and high attorney fees from PIP arbitration cases remain key contributors to the State's very expensive no-fault system. The Statement also observed that New Jersey's adverse PIP trends and significantly higher PIP losses compared to other no-fault states indicate a flawed and unbalanced no-fault system. The Statement recommended that attention be focused on the factors that are threatening to undermine earlier reforms. The Statement went on to summarize the findings of the Report mentioned above. The Report found that:

- The amount paid for New Jersey's no-fault PIP coverage is second highest in the nation, which explains why the State's overall premium continually ranks in the top

two. The Report noted that New Jersey insureds pay on average $100.00 more for PIP coverage than their counterparts in other no-fault states. The commenter asserted that the PIP coverage is much more important component of the total liability coverage in New Jersey than it is elsewhere.

- The main contributor to New Jersey's very high PIP premium is the cost of the no-fault PIP claim, which is four times higher than other states' average PIP claim cost. Specifically, New Jersey's per-claim PIP severity exceeds New York by twice as much and Pennsylvania by four times as much.

- PIP claim severity has risen more quickly in New Jersey than in other states. Over the past decade, PIP severity in New Jersey increased 65 percent (from $9,900 to $16,400 per claim) almost two times greater than the growth rate for other no-fault states combined.

- The PIP medical-expense limit of $250,000 is one of the most generous in the nation, which makes it expensive. For every $100.00 paid to cover damage to a vehicle, New Jersey insureds pay an additional $172.00 of PIP loss for injuries incurred. This is almost a third more than insurers' average PIP payment (per $100.00 of vehicle damage) in other no-fault states.

- The significance of the medical care component in New Jersey's PIP losses has grown immensely over the years. In 1997, medical costs represented 75 percent of total PIP losses (remaining portions include wage loss, essential services, rehabilitation, and funeral expenses). A decade later, medical costs now represent an overwhelming 96 percent of total PIP losses, which is higher than elsewhere.

- Medical care costs as measured by the Consumer Price index have risen 37 percent in the last decade. New Jersey's PIP claim costs have risen 65 percent since 2001. This suggests occurrences of fraud and abuse in New Jersey's no-fault system. As examples, staged accidents have soared 67 percent in the last several years and, as indicated by the chart below, various medical professionals charge between 20 and 212 percent more to treat PIP claimants than their counterparts elsewhere.

Total Amounts Charged per PIP Claim by Medical Professionals:

New Jersey is Much Higher than Other No-Fault States

	New Jersey	Other No-Fault States	Percent Differential: NJ is higher by:
Alternative Provider	$8,807	$2,827	+211.5%
Orthopedist	$7,489	$2,765	+170.8%
Chiropractor	$6,054	$4,135	+46.4%
Physical Therapist	$5,040	$3,353	+50.3%
Neurologist	$2,301	$1,904	+20.9%

Source: Insurance Research Council, 2007

- American Hospital Association data shows that hospitals are shifting costs to all New Jersey private insurers by almost 4.4 times their actual costs. This ratio is the highest in the nation, imposing a subsidy of roughly $710 million on the State's personal auto insurers in 2009 (or about $130.00 per insured vehicle).

- New Jersey's PIP arbitration process encourages filings over disputed medical bills, regardless of the monetary value. At times, settlements can result in excessively high attorney fees, some of which exceed the value of the actual award by a large

amount. These disproportionally high attorney fees have led to New Jersey's auto insurers spending much more on no-fault related defense costs, relative to premiums. In 2009, their defense costs were 16 percent of premiums, while the countrywide average defense costs were seven percent of premiums.

The Statement concluded by asserting that drivers in New Jersey are paying significantly more than their counterparts elsewhere in the country due to fraud, high-medical costs and high attorney fees that have led to a broken no-fault system. The Statement observed that the proposed regulations are good first step in implementing a comprehensive reform of the New Jersey no-fault system but that further changes will be needed.

RESPONSE: The Department appreciates the support and agrees that the adopted amendments will further cost-containment of PIP claims and will enable faster, more predictable resolution of disputes regarding the provision and reimbursement of medical benefits under PIP.

COMMENT: Several commenters expressed their appreciation for the opportunity to engage in dialogue with the Commissioner and key staff as the rulemaking was being developed. As a result, the proposal represented a balanced approach to revising the PIP system. Several commenters expressed their appreciation that the proposal reflects the concerns of providers about shifting the current PIP system to a managed care environment.

RESPONSE: The Department appreciates the support. Specifically, the Department believes that the adopted amendments and the expansion of the fee schedules will further cost-containment of PIP claims and will enable faster, more predictable resolution of

disputes regarding the provision and reimbursement of medical benefits under PIP.

COMMENT: One commenter commended the Department on the proposal, noting that some changes, especially those relating to the arbitration system, are long overdue. The commenter expressed concern about the increased medical reimbursement levels in the new proposal. The commenter believes that the increase is not justified and will result in higher claim costs, and fewer available dollars for a policyholder's medical treatment, and will put upward pressure on insurance rates to keep pace with rising medical costs. The commenter also is supportive of making hospital outpatient services subject to a fee schedule and requested that the Department propose a fee schedule for hospital inpatient services. The commenter concluded by stating its belief that this proposal may help stem some of the mounting losses in the PIP system and restore some balance but it is not the ultimate solution to the problems with PIP. The commenter urged the Department to continue to explore cost-control options that will preserve the value of the policyholder's PIP benefits.

RESPONSE: The Department appreciates the support. The Department believes that the increases in fees are justified by cost of living increases that have been factored into Medicare fees since 2007. The Department has no immediate plans to propose a hospital inpatient services fee schedule but will continue to explore other cost-control options for PIP.

COMMENT: One commenter thanked the Department for attempting to contain costs in an efficacious manner with regard to the process for pre-certification requirements. The commenter noted that N.J.S.A. 39:6A-4.a provides for consultation with applicable

licensing boards when reviewing, modifying and/or rejecting the use of standards, protocols, and practices and welcomes the opportunity to interact with the Department to make the proposal better.

RESPONSE: The Department appreciates the support.

COMMENT: Another commenter stated that if the Department wants to save money, it should remove the cumbersome precertification process, and provide for electronic billing and electronic funds transfer of payments.

RESPONSE: The Department agrees with the commenter that electronic billing and payment, which has already been widely implemented for health insurance, should be introduced for PIP. However, such a change is outside the scope of this proposal. The Department does not agree with the commenter that the precertification process should be removed. First, the process is mandated by statute and second, utilization review is a universally accepted method of preventing overutilization and ensuring that patients receive reasonable, necessary, and appropriate treatment as required by N.J.S.A. 39:6A-4.

COMMENT: One commenter stated that it had reviewed the changes in the proposal and opposed them on the grounds that there is no proof that PIP is exerting "upward pressure" on rates. The commenter asserted that previous legislative and regulatory changes have had the effect of containing the cost of PIP benefits and have created a more competitive marketplace for auto insurance. The commenter asserted that the proposal would decrease the value of the PIP benefit to injured persons by making it more difficult to obtain quality medical care. The commenter stated that the data the Department is using is both stale and misleading and does not depict the most current trends in the cost of PIP

benefits. The commenter asserted that there is strong evidence that the number of PIP claims and the cost per claim is decreasing and that insurers are currently paying PIP benefits of only $0.84 for every dollar of premium earned, not $1.23. The commenter cited the 2003 legislative and regulatory changes (P.L. 2003, c. 89) to the auto insurance statutes and the promulgation of PIP medical fee schedules beginning in 1991, which culminated in the amendments to the free schedule (*In re Adoption of N.J.A.C. 11:3-29*) upheld in 2009 by the Appellate Division to argue that the cost of providing PIP benefits have already been lowered and, therefore, the 10-year average used by the Department for the evaluation of PIP costs in New Jersey is inflated because it does not reflect these structural changes in the auto insurance system. The commenter stated that the cost of PIP was considerably higher for the first five years of data used (2000-2004) than the cost for the last five years (2005-2009).

The commenter also argued that the Department's use of the ratio of "incurred losses" to premium rather than "paid losses" is misleading because "incurred losses" are a less accurate reflection of the true costs of automobile insurance. Using the paid loss ratio for PIP, the commenter stated that the National Association of Insurance Commissioners (NAIC) report shows a 118 percent loss ratio from 2000 to 2009.

The commenter stated that while the data used by the Department stops in 2009, more recent data indicates that the loss ratio for PIP benefits has dropped below $1.00 for 2010. In support of this assertion, the commenter cited a Moody's Weekly Credit Outlook, which stated that the ten biggest writing auto insurers in New Jersey have reported an average loss ratio of 84 percent for no-fault auto insurance based on Highline Data.

RESPONSE: The Department does not agree with the commenter. At the outset, the Department rejects the argument that the loss experience or profitability of insurers should determine Department policy on PIP fee schedule rule making. As discussed more fully below, the Department believes that the data demonstrates that PIP loss experience continues to exert an upward pressure on auto insurance rates but that is only one factor in promulgating this rule. The Department is making the statutorily required cost of living changes to the medical fee schedules, incorporating changes in medical terminology and practice and closing loopholes exploited by some providers that are depriving insureds of the full benefit of their claim dollar and fulfilling the cost containment mandate of N.J.S.A. 17:33B-42, which exists irrespective of loss ratios or profitability. The Department also does not believe that its proposed rules are decreasing the value of the PIP benefit to the insured by making it more difficult for insureds to obtain care. On the contrary, as noted above the proposed rules are increasing the value of the PIP benefit by addressing overutilization, exploitation of loopholes and fraud by unscrupulous providers that deprive insureds of the full benefit of their claim dollar.

The Department does not agree that it used stale data when the rule was proposed. At that time, 2009 data was all that was available. The commenter is correct that the loss ratios for PIP, whether of incurred or paid losses, have decreased over the last 10 years. The Department also does not agree that its use of "incurred losses" is misleading. Both paid and incurred losses are used in ratemaking. However, as discussed more fully below in response to other comments, the decrease in PIP loss ratios is not because of a significant decrease in the frequency or severity of PIP claims, it is because PIP premiums have increased. A loss ratio is calculated by dividing premiums by losses and

expenses. The ratio can be lowered by a decrease in losses or an increase in premium and the data shows that premium has been increasing faster than losses. The unfavorable PIP experience of insurers, which results in high loss ratios, has justified rate increases that have gradually reduced those loss ratios. This is the "upward pressure on rates" referred to by the Department.

COMMENT: One commenter, citing New Jersey Fast Track insurance data from the National Association of Insurance Commissioners (NAIC), asserted that the increase in PIP premium has outpaced the payments made for PIP claims. The commenter stated that from 2000-2009, the premiums earned from PIP have increased by 43.1 percent while during the same time, the total paid loss and Defense and Cost Containment Expense (DCCE) increased by only 24.8 percent. The commenter claimed that this means that the increase in PIP premiums over 10 years has almost doubled the increase in PIP payments. The commenter asserted that it is the insurers' demand for increased premiums and profits that have exerted an "upward pressure" on PIP rates, not the increase in PIP payments.

RESPONSE: The Department does not agree with the commenter's conclusion. As noted above in response to another comment, the increase in PIP premiums is a direct result of the history of high loss ratios in PIP. For many years, insurers have been paying out more in claims than they collected in premium. Insurers have been gradually increasing rates in response to the unfavorable loss experience of the PIP coverage. As discussed more fully below in response to another comment, the increased premiums are being used to offset the high loss ratios and the increase in paid losses shown in the Fast Track Results cited by the commenter.

COMMENT: One commenter stated that there is strong evidence that the number of PIP claims and the cost per claim is decreasing and insurance companies are making a significant profit on auto insurance. In support of its position, the commenter cited recent NAIC Fast Track data. The data shows that the number of paid PIP claims was 8,566 for the first quarter of 2010 and that was down to 7,354 claims in the first quarter of 2011, a reduction of 14 percent. The commenter concluded that this data refutes the Department's assertion that PIP is currently exerting an "upward pressure" on private passenger auto insurance rates.

RESPONSE: The Department does not agree with the commenter. The commenter has chosen two quarters of data to support its claim that the frequency and severity of PIP claims has declined. However, a review of the latest Fast Track private passenger no-fault year-end claim severity data as of December 31, 2011, set forth below, shows that average severity has been rising during the period except for 2010 when there was also a small increase in frequency but a decrease in severity. In 2011, severity increased to slightly above 2009 levels and, except for 2010, frequency is almost unchanged. The Department also notes that Fast Track data only represents information from about 55 percent of the market. The Department continues to believe that PIP loss ratios are putting upward pressure on rates.

Fast Track Data @ 12/31/2011

	# Paid Claims	Average Severity	% Change in Severity
2007	30,754	14,653	
2008	30,584	16,075	9.7%
2009	30,780	17,261	7.4%
2010	32,666	16,468	-4.6%
2011	30,270	17,766	7.9%

COMMENT: One commenter stated that the Department's concentration on the loss ratios for PIP overlooks the favorable overall experience of all Private Passenger Automobile (PPA) insurance lines in New Jersey including liability and property damage. The commenter asserted that the Fast Track NAIC data shows that the "incurred loss/DCCE" ratio from 2000-2009 was 123.5 percent. However, the same ratio for "total liability and physical damage" was only 68.8 percent. The "paid loss/DCCE" ratio to earned premium for PIP for the same time period was 118.1 percent while the same ratio for "total liability and physical damage" was also 68.8 percent. The commenter concluded that the losses for the other PPA lines was low enough to offset the losses for PIP so that insurers kept 30 cents profit for every dollar they took in.

RESPONSE: The Department does not agree with the commenter. First, insurers make rate filings for individual coverages and one coverage is not intended to subsidize another. Second, the Fast Track data cited is loss experience only. Insurers must also use the premium they collect for underwriting and other claim expenses. According to the 2010 Insurance Expense Exhibit for Private Passenger Auto Liability (lines 19.1+19.2 Combined, Countrywide), these expenses represent approximately 34 percent of premium. Therefore, insurers are not keeping 30 cents profit for every dollar they take in.

COMMENT: One commenter stated that the loss ratio for PIP (based on direct premiums written) compares favorably with the 11 other states with no-fault insurance laws. The commenter asserted that the 2010 Highline Data indicates that New Jersey has a PIP loss ratio of 84 percent, which is lower than the average of 113 percent for all no-fault states.

RESPONSE: The Department does not believe that the loss ratios of no-fault insurers in

other states, which have different laws and insurance limits, have any relevance to New Jersey. The Department notes that other commenters submitted comparisons with other no-fault states which belie the assertions submitted by this commenter. Additionally, any comparisons with other no-fault states, whatever their conclusions, do not obviate the Commissioner's statutory duty under N.J.S.A. 17:33B-42 to implement any procedure or practice that he deems necessary to more effectively control the cost of providing PIP coverage to insureds in this State.

COMMENT: One commenter noted that there are many factors that will make the cost of automobile insurance coverage higher in New Jersey than other states. These include: a high population density; a high median income; a highly urbanized population; and high mandatory insurance benefits including $250,000 in PIP coverage taken by most drivers. Based on these statistics, the commenter asserted that the cost of the PIP coverage is not exerting upward pressure on rates.

RESPONSE: The Department does not agree with the commenter. The commenter has enumerated the reasons that auto insurance premiums in New Jersey are higher than those in other states. Those factors are not relevant to whether the rates for the PIP coverage in New Jersey are adequate or whether the Department should make statutorily required updates to the fee schedules, address overutilization, exploitation of loopholes, and fraud by amending its rules for the PIP coverage.

COMMENT: One commenter stated that the Department noted that there had been many legislative and regulatory changes over the years that have stabilized or contained the cost of the PIP coverage. These include the PIP Protocols, PIP Medical Fee Schedules,

policy options, and fraud prevention. The commenter asserted that the Department failed to recognize the historic legislation enacted in 2003 that changed the basic structure of the competitive insurance market in New Jersey. The commenter stated that these changes have created a vibrant, competitive market for auto insurance in New Jersey.

RESPONSE: The Department agrees with the commenter that the historic legislation passed in 2003 helped to create a vibrant, competitive market for auto insurance in New Jersey. However, the_Department does not believe that the existence of this vibrant, competitive automobile insurance market makes it unnecessary to amend the rules governing the PIP coverage to make cost of living changes in the PIP fee schedules, address overutilization, exploitation of loopholes, and fraud by amending its rules for the PIP coverage.

COMMENT: Several commenters challenged the Department's Summary statement that carriers pay $1.23 for every dollar of PIP premium collected. The commenters urged the Department to provide its analysis for this statement and note what percentage of the entire automobile premium is spent on medical expenses, particularly physician fees. The commenters believe that the Department's statement fails to take into account the implementation of the existing PIP fee schedule in August 2009, which drastically reduced provider reimbursement, particularly for ASCs.

The commenters opined that it is essential to consider data that reflect the post-August 2009 reductions. The commenters noted that the Department's position is incongruous with what consumers perceive as an active, competitive auto insurance market. One commenter stated that at the October 6, 2011 committee meeting before the Financial

Institutions and Insurance Committee, not one insurance carrier testified that they are either losing money or are leaving the state.

RESPONSE: The Department does not agree with the commenter. As discussed more fully above in response to other comments, the Department believes that the data shows that PIP loss experience continues to exert upward pressure on rates. The Department only receives data on overall PIP premium and payments so there is no information on what part of PIP payments are made to physicians.

It is true that the 2007 amendments to the PIP fee schedule, implemented in 2009, were intended in part to address the issue of costs, but the fact that some costs have been reduced does not mean that further reforms are unnecessary. Pursuant to N.J.S.A. 17:33B-42, the Department has a statutory obligation to contain the costs of insurance coverage. This obligation exists regardless of PIP loss ratios. The Department is also seeking to avoid another personal lines private passenger auto insurance availability crisis for insureds. Should automobile insurers start to leave the state, it will be too late to effectively address problems in the market through rulemaking.

COMMENT: Several commenters stated that the Department's rationale for the rule only deals with the cost objective and completely ignores the reparation objective, which has been viewed by the courts as the "primary purpose" of the automobile insurance system. While the cost objective is one of the goals of the No-Fault Act, the Department has ignored the primary purpose, which is to provide prompt and efficient benefits for all accident injury victims. Several commenters noted that the Department has attempted to contain costs by reducing the benefits available to accident victims. Another commenter

stated that the Department has not provided social, economic, and jobs impact analyses based on actual studies but rather has provided anecdotal information. Another commenter stated that the Social, Economic, and Jobs Impacts and the Regulatory Flexibility Statement in the proposal are inaccurate. The commenter stated that in terms of the social impact, most of the amendments will solely benefit the insurers to the detriment of the insureds and consumers. In terms of the economic impact, the savings will only be to the benefit of the insurers and to the detriment of the insureds. In terms of the jobs impact, the Department has not sought out and obtained any information or surveyed providers or suppliers who would stop treating PIP patients. In terms of the regulatory flexibility analysis, the focus is on insurance companies rather than medical providers and suppliers who are attempting to survive in business. Another commenter noted that the original No-Fault Act mandated that all bodily injury insurance rates be reduced by 15 percent. There is nothing in the proposed rules that mandates a reduction of PIP insurance rates. Thus, on its face, the proposed rules will increase the profitability of the insurers with no equivalent benefit to the policyholders.

RESPONSE: The Department does not agree with the commenters. First, the rule increases most of the fees for the services that are on the existing fee schedule, which benefits providers. Second, the rule increases PIP benefits available to insureds by addressing overutilization and loopholes exploited by unscrupulous providers and other abuses such as excessive attorney fees. These unnecessary costs eat up an insured's PIP benefit, which may leave insufficient funds for medically necessary treatments. Furthermore, the rules and expanded fee schedules will provide cost certainty on a greater number of medical procedures which will serve to facilitate prompt review and approval

of medical treatments and reimbursements to providers when the procedures sought are reasonable, necessary and appropriate as provided for in N.J.S.A. 39:6A-4.

The Department also does not agree that the proposal ignores the primary purpose of the No-Fault Act, which the commenter stated to be, "the providing of prompt and efficient benefits for all accident injury victims." In addition to preserving the PIP benefit for insureds mentioned above, the internal appeal system in the rules, once effective, will provide a prompt and efficient review of decisions by insurers. Likewise, the registration process for PIP vendors will ensure that these entities are providing quality and consumer-friendly services to insurers to the benefit of insureds and providers alike.

With regard to the impact statements, the Department also does not agree with the commenters. The Department is not obliged to conduct studies to determine the economic, jobs, and social impact of its proposals. As was noted in the notice of proposal, the Department is not aware of any such studies that have been done. The Department notes that the commenters have not provided any studies of their own addressing these issues. Finally, the Department does not have the authority to order mandatory rate rollbacks, which can only be done by statute, nor does it believe that such a rollback would be appropriate. New Jersey is currently a competitive market for auto insurance. Cost savings that are achieved by the implementation of the reforms in the rule will be reflected in the containment of insurance rates by counteracting the upward pressure PIP claims has continued to exert on auto premiums. However, as noted in the Summary to the notice of proposal, over the last 10 years, PIP premiums have lagged behind the PIP loss experience due at least in part to rising medical costs. Overall, there is nothing in the adopted rule that in any way reduces the benefits available to insureds

and in total, these reforms will increase benefits to insureds by eliminating waste, fraud, and inefficiency.

COMMENT: Several commenters urged the Department to hold a public hearing on this rulemaking because the proposed rules are not going to help consumers or the medical providers that serve them. The commenters expressed concern that the proposed rules will impair the ability of accident victims to obtain prompt and appropriate treatment from doctors of their choice, impair the ability of doctors to be promptly and fairly compensated, and will impair the ability of doctors and patients to exercise their legal rights in the resolution of PIP disputes.

RESPONSE: The Administrative Procedure Act at N.J.S.A. 52:14B-4(a)(3) requires that each State agency shall develop its own standard for what constitutes "sufficient public interest" for holding such a hearing. The Department's rules at N.J.A.C. 11:1-15.5(c) provide that sufficient public interest is demonstrated, "if upon reviewing the request, the Commissioner determines that additional data, findings and/or analysis regarding the notice of proposal are necessary for the Department to review prior to adoption of the proposal in order to ensure that the notice of proposal does not violate the intent of the statutory authority."

The comments do not meet the requirements for demonstrating sufficient public interest set forth above, as nothing in them indicates that there is any additional data, findings, or analysis that are necessary for the Department to review to ensure that the proposal is consistent with the intent of N.J.S.A. 39:6A-4 et seq.

In addition, the Department believes that it has provided abundant opportunities for

public comment on the initial proposal and the notice of proposed substantial changes. Prior to the initial proposal being submitted to the Office of Administrative Law, the Department held at least a dozen meetings with representatives of various interested parties, including attorneys and physicians. In addition, the fee schedule appendices included in the proposal were made available for a week for interested parties to review. When the initial proposal was published in the New Jersey Register, a 60-day comment period was provided, which the Department subsequently extended for an additional 17 days. When the notice of proposed substantial changes was published, a 60-day comment period was provided on the proposed substantial changes articulated therein.

Additionally, the Department does not agree that the adopted rules and expanded fee schedules will impair the ability of accident victims to obtain prompt and appropriate treatment or of doctors to be promptly and fairly compensated, nor will it impair the ability of doctors and patients to exercise their legal rights in the resolution of PIP disputes. Rather, the amendments as proposed will: enhance the efficiency of the PIP system by providing for prompt internal appeals prior to arbitration; provide expanded cost certainty, which will speed responses to decision point review and precertification requests and eliminate the need for usual, customary, and reasonable (UCR) determinations and reimbursement arbitration; and provide more efficacious and prompt arbitration reviews of nominal reimbursement disputes and limit wasteful expenditures of PIP benefits on attorneys' fees that are not consonant with the amounts of those arbitration awards as required by N.J.S.A. 39:6A-5.2.g.

COMMENT: One commenter noted that several of the reforms in the proposal require new or revised forms and filings that must be approved. In addition, the regulatory

changes are substantial and will require careful retooling of PIP claim processing practices. The commenter requested that effective dates of no less than six months be provided to make these changes. The commenter also requested that the Department provide additional time to insurers who need it.

RESPONSE: The Department does not agree that the operative date of the entire adoption should be delayed for six months. As discussed more fully below in response to other comments, the Department believes that the internal appeal process needs to be amended in consultation with the insurers and providers. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date of 365 days for the internal appeals process, which will allow time for amendments to be drafted, proposed and commented upon, and adopted. Therefore, insurers will not be required to refile their DPR plans until this rule becomes operative. The remainder of the rule will become operative in 60 days, which the Department believes is sufficient time to implement the changes.

COMMENT: One commenter noted that upon adoption of the proposed amendments, insurers will be required to refile their DPR plans. The commenter requested that the Department make a written commitment to review and provide feedback on such plans within 30 days so that insurers know that they may use their DPR plans. Alternatively, the commenter requested that DPR plans should be deemed approved if the Department does not act within 30 days.

RESPONSE: The Department does not agree with the commenter either that it should

commit to a 30-day turnaround for review of DPR plan filings or permit such filings to be deemed approved after 30 days. Insurers will be required to refile their DPR plans to implement the Internal Appeals Procedure mandated by N.J.A.C. 11:3-4.7B. As noted above, the Department is establishing a 365-day delayed operative date for the internal appeals procedure. When this part of the rule becomes operative and such plans are filed, the Department will make every effort to review and approve such filings in a timely manner, but because the DPR Plan is the primary means by which the insurer interacts with providers and insureds when an insured has been injured in an auto accident, it is important that the filings be reviewed carefully.

COMMENT: One commenter asked if vendors and insurers would be required to refile their DPR plans and policy forms. The commenter asked what the timeline for these filings would be and noted that it would be an expensive process for PIP vendors, insurers, and the Department.

RESPONSE: As noted above, vendors and insurers will have to refile their DPR plans to make changes required by the adoption of the amendments to N.J.A.C. 11:3-4.7B. However, the operative date of these amendments has been delayed for 365 days. In addition, insurers will have to refile policy forms to make other changes required by the amended rule. Changes to policy forms receive effective dates when approved by the Department. The Department recognizes that changes to these documents will entail some costs for all parties but they are necessary to implement the reforms contained in the adoption, and these costs are outweighed by the impact of these reforms which will provide further PIP cost-containment and benefit insureds by maximizing the amount of their PIP benefits and by further ensuring efficient and timely provision of reasonable,

necessary and appropriate medical treatment.

COMMENT: One commenter stated that if there is a desire to reduce auto insurance rates in New Jersey, one way would be to reduce the unnecessary paperwork, appeals process, and litigation. The commenter recommended that physicians be allowed to treat the patient and not be denied services because of a paperwork error. This would allow the injured to get better treatment and the physician to practice medicine and not become a bookkeeper. The commenter opined that this alone would save insurance companies hundreds of thousands of dollars by eliminating the unnecessary expense of punishing physicians for not filling out a form properly. In addition, the insurance companies could save millions of dollars by negotiating settlements with plaintiffs' counsel and settling the thousands of arbitrations.

RESPONSE: The Department does not agree with the commenter. Unfortunately, many of the paperwork requirements exist because of unscrupulous providers who have driven up PIP costs by overtreatment and exploitation of loopholes in the rules and due to the insurance fraud that persists in auto insurance and the provisions of PIP benefits. The Department believes that its rule does not put unnecessary burdens on providers to get treatments approved. As for insurers settling arbitrations, that is outside the scope of the proposal; however, the Department notes that the expanded fee schedules and the “on-the-papers” arbitrations for nominal reimbursements will eliminate the need for many arbitration hearings and will expedite the arbitration process, thus these reforms meet the stated goals of the commenter through different means.

COMMENT: One commenter noted that it is generally supportive of the proposed

comprehensive changes to the PIP program, but urged the Department to continue its vigilance on the sources of information used to establish both the fee schedule and the UCR fees. The commenter expressed concerns that a lack of fee transparency and reduced fees will have a negative impact on access to care and quality care.

RESPONSE: The Department appreciates the support. The Department fully disclosed the sources of the fee schedule in the notice of proposal and the fact that the methodology utilized was approved by the Appellate Division in the last round of PIP amendments, and the method of calculating UCR is not being substantively amended here and was similarly affirmed by the court. See *In re Adoption of N.J.A.C. 11:3-29*.

COMMENT: One commenter noted that while the CPT codes in the proposed fee schedule, on average, are not reduced, the economic analysis of the rule did not mention the negative impact on specialty practices whose fees will be reduced.

RESPONSE: There are more than 2,000 fees on the physicians' fee schedule and the majority of them are increased in the proposal. The Department does not believe that the few fees that are reduced because of changes to work and practice Resource Based Relative Value Units (RBRVUs) by CMS will have a significant economic impact on specialty practices. The commenter did not supply any data to support this assertion.

COMMENT: One commenter stated that the new PIP regulations are "unacceptable" and cannot be modified in a manner that would ever be acceptable or suitable to severely injured patients/victims. Several commenters claimed that the proposed rules create an undue burden on all parties providing care and treatment as well as on the victims themselves, and that only the automobile insurance companies benefit from these new

rules. The commenters opined that the proposal imposes additional constraints on an already restrictive process. Several commenters stated that patients' rights, especially in regard to their freedom of choice to select their own doctors and/or to receive appropriate diagnostic services, are not enhanced. Another commenter stated that the proposed fee schedule is unsupported by readily available market information and bears no relationship to the 75th percentile of what practitioners were actually paid for such services before the fee schedule was adopted. Another commenter noted that some of the well intentioned proposed changes will have a large negative impact on many small businesses of healthcare providers.

RESPONSE: The Department does not agree with the commenters and believes that the proposal will benefit patients, providers, and insurers. The commenters have not provided any specific information as to how the adoption constitutes an "undue burden" or how it would affect a patient's ability to choose his or her own doctor for treatment or how it will have a negative impact on small businesses. In setting the fee schedules, the Department has followed the procedure upheld by the Appellate Division and has reviewed the available data on paid fees. This data includes Medicare, the largest health payor in the United States, which uses a resource-based relative value system of setting fees developed and maintained by physicians, FAIR Health allowed fees, fees paid by auto insurers, and the New York Workers Compensation fee schedule, which is also a resource-based value scale. The Department is not aware of any other sources of paid fee data.

COMMENT: Several commenters noted that the Summary of the proposal does not note what percentage of the entire automobile premium is spent on medical expenses,

particularly physician fees. While auto insurers remain financially stable, physicians' practices continue to suffer from flat and falling fees that do not keep up with the pace of practicing medicine and physicians trained in New Jersey are leaving the State after their residencies at a rate of over 60 percent.

RESPONSE: The Department does not have any data on what percentage of PIP medical expenses are paid to physicians as opposed to hospitals and other providers. The amount of PIP medical expenses paid by insurers is reported in one sum, not broken out by type of treatment or type of provider. The Department believes that payments for the treatment of PIP patients exceed what is paid to providers under most health care plans. In addition, PIP is a very small percentage of all medical expense payments so the Department does not believe that PIP reimbursement levels are causing new physicians to leave the State.

COMMENT: One commenter stated that physical therapists should be exempted from the proposal because, unlike any other professionals in New Jersey, regulations promulgated by the licensing Board of Physical Therapy Examiners address many of the concerns expressed in the rule proposal, and prohibit charging excessive fees, overutilization, and seeking payment for services that are unnecessary. The proposed rules would provide excessive, redundant, and conflicting regulation of the patient-provider relationship and likely result in few choices for consumers, longer waiting time for providers, and confine public access ultimately to only "high- volume" practices rather than high-quality practices.

RESPONSE: The Department does not agree with the commenter. While it is true that

the Board of Physical Therapy Examiners is very active in regulating the practice of physical therapy in New Jersey, the Department believes that its rules must also apply to physical therapists in order to fulfill the Commissioner's statutory responsibilities for PIP under N.J.S.A. 39:6A-4 and 6.4. Furthermore, the Department avers that its adopted PIP rules and fee schedules are complementary to the professional regulation of physical therapy and merely provide additional measures to prevent overutilization of treatment and preserve the value of the insured's PIP benefit. The Department notes that, unlike the policies of many health payors, there are no limits in the PIP coverage on the number of physical therapy visits that an injured person can receive.

COMMENT: One commenter stated that the proposal should not be adopted because it does not promote the cost-efficient provision of quality medical care to persons injured in automobile accidents as required by N.J.S.A. 39:6A-4 et seq. The commenter believed that most of the proposals are intended solely for the benefit of insurers instead of injured persons and providers. The commenter stated further that many of the provisions of the proposal exceed their statutory authority. The commenter expressed his belief that any reform of PIP must come from the Legislature, not the Department, and that the Department is only required to perform its biennial review of the fee schedules, not reform PIP and alternate dispute resolution. The commenter also stated that the Department seems to have forgotten its purpose and mission to protect consumers.

RESPONSE: The Department does not agree with the commenter. As noted above in response to other comments, the Department believes that the proposal benefit insureds by preserving the value of their PIP benefit dollar for treatments that are reasonable, necessary, and appropriate as required by N.J.S.A. 39:6A-4. Contrary to the

commenter's assertion, the Department is given wide authority in the statute to regulate the PIP benefits under auto policy. For example, the Legislature directed the Commissioner: to approve PIP benefit plans contained in auto policies; approve the insurers' policy forms; establish by regulation a statement of the basic PIP benefits which shall be included in the policy; establish standard care paths or protocols for the treatment of PIP injuries; reject protocols and diagnostic tests deemed not to have standing or general recognition by the provider community and licensing boards; and approve pre-certification requirements in policies. (See N.J.S.A. 39:6A-4.) As recognized by the Appellate Division, the Legislature also provided that the Commissioner may promulgate any rules or regulations necessary to effectuate his broad powers under the PIP statutes. N.J.S.A. 39:6A-1.2; *Coalition II*, *supra* 348 *N.J. Super* at 285. Furthermore, the Commissioner has been tasked by the Legislature with the creation of fee schedules for the reimbursement of PIP benefits to providers pursuant to N.J.S.A. 39:6A-4.6. Thus, the Department believes that these new rules, amendments, and fee schedules are well within the statutory authority and mission of the Department.

N.J.A.C. 11:3-4 PIP Benefits; Medical Protocols; Diagnostic Tests

COMMENT: One commenter questioned why, in various parts of the proposal, the Department appeared to be authorizing providers to use a power of attorney as a substitute for an assignment of benefits. The commenter stated that no authority for the use of such a document was specified in the rule and, on the contrary, N.J.S.A. 39:6A-4 requires an assignment of benefits. The commenter recommended that the rule be amended upon adoption to delete the references to powers of attorney.

RESPONSE: The Department is not authorizing the use of powers of attorney. It is the Department's understanding that some providers are already using powers of attorney to try and avoid the requirements attached to assignments of benefits. N.J.S.A. 39:6A-4 states that PIP benefits are not assignable except to a provider of service benefits. The statutory language is silent as to powers of attorney. The purpose of the rule provision is to make it clear that no matter what instrument a provider uses to get direct payment from the insurer, the restrictions set forth in the rule apply.

N.J.A.C. 11:3-29.2

COMMENT: One commenter requested that the Department confirm that the term "bill review" used in the definition of "utilization management" means review of the bill for medical necessity, proper coding, fee schedule, or UCR adjustments and would not include bill audits to verify causality.

RESPONSE: The Department certainly intended that the definition of "bill review" as used in the definition of "utilization management" include review of bills for proper coding and fee schedule or UCR adjustments. The Department is not clear on what the difference is between a bill review for "medical necessity" and a bill audit for causality. The Department requests that the commenter provide additional information on how and why such a distinction should be made.

COMMENT: One commenter asked for clarification as to whether the application of the definitions of "PIP vendor" and "utilization management" would require an entity that simply arranged for doctors to provide independent medical examinations (IMEs) on behalf of a PIP insurer but does not receive or interpret IME reports to register as a PIP

vendor. The commenter also requested that an individual physician or group of physicians who actually perform IMEs on behalf of an insurer not be considered as PIP vendors.

RESPONSE: The Department notes that the definition of "utilization management" includes scheduling and performing IMEs. The Department requests that the commenter provide additional information as to why it believes that the services it provides would not subject it to registration as a PIP vendor.

COMMENT: One commenter requested that the Department clarify the definition of "utilization management" to state that it does not prohibit an insurer from managing pre-certification and medical necessity in-house.

RESPONSE: The Department does not agree that the definition of "utilization management" needs to be clarified. Nothing in the definition could be interpreted as authorizing or prohibiting any specific entity from providing utilization management. It is the definition of "PIP vendor" that refers to insurers that contract out this activity in whole or in part.

COMMENT: One commenter requested that the definition of "utilization management" should exclude the scheduling and performance of IME's. The commenter noted that URAC's definition of "utilization management" does not include the scheduling and performance of IMEs. Another commenter stated that the No-Fault Act provides that an insurance company may require an injured person to submit to an examination whenever the person's medical condition is material to a PIP claim. The cost of the examination is borne entirely by the carrier who made the request. The carrier designates the doctor,

who will perform the exam and pays the cost. In practice, carriers regularly use the same doctors to perform these examinations. Under these circumstances the medical exams mandated by the No-Fault Act are not IMEs, but rather are PIP examinations.

RESPONSE: The Department does not agree with the commenters. The commenter has not provided any reason for the exclusion of scheduling and performance of IMEs from the definition of "utilization management" other than the fact that the URAC does not include it in its definition. Since IMEs are performed very commonly in the PIP context, the Department believes it is reasonable to include that activity in the definition of "utilization management." The Department also does not understand the commenter's purpose in characterizing the examinations mandated by N.J.S.A. 39:6A-13.d as "PIP examinations" instead of the more commonly used "independent medical examinations."

COMMENT: One commenter stated that while the Automobile Insurance Cost Reduction Act (AICRA) was enacted to save money, premiums for automobile insurance have not been reduced. The commenter also asserted that the "care paths" were implemented to determine medical pathways and govern care, but are now being used to deny care. The commenter also believed that the "IME" process has been "perverted" from its original intent, that only insurers are saving money, and all of this is confusing to patients.

RESPONSE: The Department does not agree with the commenter that the provisions of AICRA, which was enacted 13 years ago, are relevant to the proposed amendments and new rules. In 1998, the Legislature passed the AICRA, a comprehensive reform to the State's private passenger automobile insurance system and no-fault law in order to

support an overall 15 percent reduction in insurance rates. (P.L. 1998, c. 21 and 22.) A significant feature of AICRA is that it authorized the Commissioner to adopt regulations that defined standard treatment protocols with precision, as well as diagnostic tests and services reimbursable under the PIP component of automobile insurance policies, in order to reduce unnecessary treatments and overutilization of PIP benefits. Overall, AICRA reiterated the Legislature's strong commitment to contain spiraling auto insurance costs through establishment and utilization of PIP fee schedules that set maximum dollar amounts for reimbursement of PIP medical expenses by auto insurers. The aims of the AICRA amendments and the law's mandates to the Commissioner remain relevant and applicable today. Additionally, the use of IMEs is outside the scope of the proposal because the Department has not proposed any amendments affecting the usage of IMEs by insurers.

COMMENT: Several commenters believed that the Department's definition of "standard professional treatment protocols" ought to be clearer so that insurers and providers can move forward confidently. The commenters inquired as to whether there were specific guidelines that could be cited such as the National Guidelines Clearinghouse, the American College of Occupational and Environmental Medicine, or the Official Disability Guidelines. One commenter strongly recommended that the Department give deference to the affected specialty society's guidelines and treatment protocols. Another commenter also inquired as to whether journal articles or position statements from recognized organizations would be acceptable, such as the position of the American Academy of Neurology on Brain Mapping. Several commenters recommended that the entity publishing the "peer review" be an established, recognized medical entity, not an

entity with an interest in establishing the validity of the treatment under review. Several commenters suggested that the definition specifically state what type of evidence is required.

One commenter suggested that the following language might be more appropriate and would provide the detail necessary to prevent the frequent build up and abuse that have become a part of the PIP landscape:

1. Standard professional treatment protocols shall be evidence-based treatment guidelines to: (a) guide effective clinical decision making; (b) ensure consistent use of proven medical practices; and (c) reduce unproven ineffective care.

2. Such protocols shall provide for high-quality medical evidence, including, in order of quality: (a) randomized controlled trials; (b) prospective cohort studies; (c) retrospective cohort studies; (d) case-control studies; and (e) anecdotal observations, if any.

3. All treatments, irrespective of date of injury, shall be in accordance with the most recent edition of evidence-based guidelines published by the American College of Occupational and Environmental Medicine.

One commenter indicated that this definition may impact providers who render the Manipulation Under Anesthesia procedure and provided commentary on the published medical evidence for this procedure, noting that many of the published studies are of case report or case series variety.

Another commenter urged the Department to adopt procedures that will give the

regulated community notice of any test or treatment protocol that is under review and an opportunity for the regulated community to participate in any deliberation over the propriety of such a test or protocol. Deliberate fact-finding should be conducted on any protocol or test that may be disallowed. Another commenter asked that the Department confirm in the rule that the existence of a CPT code or its presence on the fee schedule is not evidence that the procedure is compensable absent clinical support in peer reviewed journals.

RESPONSE: The Department agrees with the commenters in part. The National Guidelines Clearinghouse, the American College of Occupational and Environmental Medicine, and the Official Disability Guidelines are certainly sources of standard professional treatment protocols. Amending the rule upon adoption to include a list of the sources of such protocols would be a substantive change requiring additional notice and opportunity for public comment. The Department will monitor implementation of the new definition to determine if additional amendments are warranted. As noted below in response to another comment, the practice of evidence-based medicine is widely accepted and the Department is surprised that there is confusion about the application of this practice to PIP. The Department recognizes that the adoption of the definition of "Standard Professional Treatment Protocols" may affect certain treatments currently being performed, such as Manipulation Under Anesthesia (MUA), for which there are few or no published studies that meet the standard. However, the Department believes that implementation of evidence-based standards to PIP will benefit patients by directing their PIP claim dollars to treatments that have been shown to be safe and effective. The Department does not agree with the commenters who suggested that there be needs to be

notice and an opportunity to participate in the determination of the propriety of a test or protocol. The efficacies of tests and protocols have already been determined based on evidence published in peer-reviewed journals.

COMMENT: Several commenters opposed the new definition of standard professional treatment protocols because there is nothing in the No-Fault Act that requires "commonly accepted" protocols to be peer reviewed and therefore the requirement is beyond the scope of the law. One commenter stated that simply appearing in a published, peer-reviewed journal does not establish the national and community standard of care. The proposal appears to be arbitrary and capricious and not within the national and community standards of care.

One commenter noted that there is no evidence that the Department followed the statutory mandate in N.J.S.A. 39:6A-4.a and consulted with the designated commissioners or licensing boards on this issue. The commenter also maintained that the definition improperly eliminates other methods such as expert testimony of general acceptance. Another commenter noted that the proposed language conflicts with the definition of "medical necessity" established in *Thermographic Diagnostics v. Allstate*, 125 *N.J.* 491, 507 (1991) that provides that a medically necessary treatment, procedure, or service is "based upon the physician's objectively reasonable belief that it will further the patient's diagnosis." The Court did not require that the objectively reasonable belief be supported by peer-reviewed journals. One commenter expressed his concern that the proposed change in the definition will have negative implications for the patient who needs treatment that has not met the standard definition and that the new definition will be used to provide a blanket mechanism for treatment denial.

RESPONSE: The Department does not agree with the commenters. N.J.S.A. 39:6A-4 states that, "Medical treatments, diagnostic tests, and services provided by the policy shall be rendered in accordance with commonly accepted protocols and professional standards and practices which are commonly accepted as being beneficial for the treatment of the covered injury. Protocols and professional standards and practices and lists of valid diagnostic tests which are deemed to be commonly accepted pursuant to this section shall be those recognized by national standard setting organization, national or state professional organizations of the same discipline as the treating provider, or those designated or approved by the [C]ommissioner in consultation with the professional licensing boards . . ." This language was added to the statute by AICRA) in 1998 after the *Thermographic Diagnostics* decision referenced above was issued in 1991. "[T]he Legislature is presumed to be aware of judicial construction of its enactments," and the *Thermographic Diagnostics* methodology of determining medical necessity was under a prior version of *N.J.S.A.* 39:6A-4, which did not contain the above language. *DiProspero v. Penn*, 183 *N.J.* 477, 494 (2005) (citations omitted). However, even the court in *Thermographic Diagnostics* recognized that, "[t]he use of the treatment, procedure, or service must be warranted by the circumstances and its medical value must be verified by credible and reliable evidence." *Thermographic Diagnostics*, *supra*, 125 *N.J.* at 512. The Legislature's subsequent AICRA amendment provides a basic methodology on how to determine that the medical value of the treatment is verified by credible and reliable evidence by defining what constitutes standard professional treatment protocols under PIP. This post-*Thermographic Diagnostics* language specifically provides for the Commissioner to make policy determinations as to what treatment is reasonable,

appropriate and necessary, and the new definition of standard professional treatment protocols in this adoption is well within the this statutory authority. For these reasons, the Department does not believe that the medical necessity standard set forth in *Thermographic Diagnostics* has any relevance to the adopted amendments.

The Department does not agree that in proposing a definition of "standard professional treatment protocols," it failed to follow the process in N.J.S.A. 39:6A-4 to consult with the licensing boards in the Division of Consumer Affairs in the Department of Law and Public Safety and the Department of Health and Senior Services. The statute states that, "Protocols and professional standards and practices which are deemed to be commonly accepted shall be those recognized by national standard setting organizations, national or state professional organizations of the same discipline as the treating provider, or those designated or approved by the Commissioner in consultation with the licensing boards in the Division of Consumer Affairs in the Department of Law and Public Safety. The Commissioner may reject the use of protocols, standards or practices or lists of diagnostic tests set by any organization deemed not to have standing or general recognition by the provider community or the applicable licensing boards." The Department is designating protocols that are recognized by national standard setting organizations and thus is not required to consult with the licensing boards in the Division of Consumer Affairs in the Department of Law and Public Safety.

The definition of "standard professional treatment protocols" in the adopted amendments follows the practice of evidence-based medicine. "Evidence-based medicine" is defined by the American Medical Association's Physician Consortium for Performance Improvement as, "the practice of medicine that involves the integration of individual

clinical expertise with the best available clinical evidence from systematic research. Research evidence is typically reviewed in clinical practice guidelines and synthesized into clinical recommendations, from which 'evidence-based' performance measures are derived." (Physician Consortium for Performance Improvement (PCPI) Position Statement, approved, 2009).

Evidenced-based medicine is the current standard for medical treatment as recognized by national organizations such as the AMA, as noted above, and the Agency for Healthcare Research and Quality, a part of the United States Department of Health and Human Services. The Department believes that the definition of standard professional treatment protocols in the adopted amendments will improve patient care by focusing such care on treatments and protocols that have been shown in independent studies to have a beneficial effect. Care that does not meet such a standard has not been demonstrated to improve the patient's condition and leads to the exhaustion of the patient's PIP benefits, which should be available for more effective, proven, and commonly accepted medical treatment.

COMMENT: Several commenters also questioned the comparison of Medicare reimbursement to reimbursements under automobile insurance. The commenter stated that Medicare is a non-profit, Federally funded program paid into by employees, while automobile insurance is paid for by consumers who may choose from various companies and policies to fit their needs. Another commenter noted that Medicare allows a doctor to evaluate and treat a patient without the interference that is the hallmark of the PIP program, in which hurdles exist at every step and result in delay in evaluation and treatment, and sometimes prevent physicians from providing such evaluation and treatment.

RESPONSE: The Department does not agree with the commenters. The Medicare Fee Schedules are comprehensive, resource-based fee schedules that are a standard in the health-care industry. In *In re Adoption of N.J.A.C. 11:3-29*, the Appellate Division upheld the Department's use of the Medicare as the basis for the calculation of PIP fees.

COMMENT: Several commenters believed that the proposed changes are not beneficial to the consumer, will further restrict care, and will place financial incentives ahead of proper medical treatment.

RESPONSE: The Department does not agree with the commenters. As noted above and throughout this adoption, the Department believes that its adopted amendments and new fee schedules help to preserve the PIP medical expense benefit for insureds by addressing overutilization and excessive fees and by providing cost certainty for more medical treatments and streamlined decision making through internal appeals and "on-the-papers" arbitrations for nominal reimbursement disputes.

N.J.A.C. 11:3-29.4.7A

COMMENT: One commenter noted that there has been a pattern of abuse by vendors and others that routinely deny treatment without performing the proper reviews, or simply keep delaying the claim by repeatedly asking for records that have already been provided. The commenter appreciates the Department's proposed requirement that vendors be registered and meet certain standards.

RESPONSE: The Department appreciates the support.

COMMENT: Several commenters expressed concern the contracts between vendors and

insurers could become public through Open Public Records Act (OPRA) requests if the rule is adopted as proposed. These commenters suggested that as an alternative, the Department could request a certification that such a contract exists. The commenters further stated that the terms of the contracts between vendors and insurers are proprietary and highly confidential. Another commenter believed that much of the information in the contract between the insurer and vendor was not relevant to controlling PIP costs in New Jersey. Another commenter requested that this portion of the rule be eliminated or, in the alternative, that it should be automatically protected as confidential and exempt from public access so the IME vendor would not have to engage in the burdensome process of filing a request with the Department to keep the information exempt from disclosure in every case.

RESPONSE: The Department agrees in part with the commenters. The Department believes that the contract between the vendor and the insurer should be provided to the Department as part of the PIP vendor registration process. However, the Department agrees with the commenters that the contract would not be subject to OPRA on the grounds that it contains proprietary trade-secret and financial information that would give an advantage to competitors. The Department also agrees with the commenter that it is preferable that such contracts should be designated as confidential in the rule. Accordingly, N.J.A.C. 11:3-4.7A(l) is being amended upon adoption to read (addition in boldface with asterisks): "All data or information in the PIP vendor's application for registration ***and the vendor's contract with the insurer required to be submitted pursuant to N.J.A.C. 11:3-4.7(c)1*** shall be confidential and shall not be disclosed to the public, except as follows: … ."

COMMENT: One commenter stated that this provision should be expanded to include a requirement that the PIP vendors and their subcontractors be duly organized, qualified, and licensed to do business in New Jersey.

RESPONSE: The Department does not agree with the commenter and believes that the rule as proposed already requires that an entity acting as a PIP vendor be qualified. The Department does not know what the commenter means by "duly organized." The Department does not require that PIP vendors have any specific type of business organization such as being a corporation. The Department is not also aware of any licensure requirement for such entities in the State.

N.J.A.C. 11:3-4.7

COMMENT: One commenter stated that the proposed amendment to N.J.A.C. 11:3-4.7(c)6 is improper except insofar as an optional, internal appeal that is provided by an insurance carrier must appear in their DPR plan. The commenter asserted that there is no statutory basis for a mandatory, internal appeal prior to being able to file an arbitration.

RESPONSE: The Department does not agree with the commenter. N.J.A.C. 11:3-4.7(c)6 already required that insurers have an internal appeals process as part of their DPR plans. The amendment simply refers to the internal appeal process set forth in N.J.A.C. 11:3-4.7B. Moreover, pursuant to N.J.S.A. 39:6A-4, the Commissioner has the authority to establish and require DPR plans be filed by insurers, and this new requirement merely expands the required attributes of the internal appeals system. See *N.J. Coalition of Health Care Professionals, Inc., v. NJ Dep't of Banking and Ins.* ("*Coalition I*"), 323 *N.J. Super.* 207 (App. Div. 1999), *certif. denied*, 162 *N.J.* 485 (1999)

(affirming adoption of N.J.A.C. 11:3-4.7's DPR requirements as providing "consumers with access to an adequate quality of health care" while achieving the cost-containment objectives of AICRA).

COMMENT: One commenter stated that the ability of insurers to restrict which vendors can submit Attending Provider Treatment Plan (APTP) forms provided by N.J.A.C. 11:3-4.7(c)8 should be extended to other types of providers such as physical therapists. The commenter believes that only the medical doctor should submit requests for further physical therapy. The commenter believes that since denial of treatment requests can only be made by a physician, having only physicians submit the requests would bring consistency to the process.

RESPONSE: The Department does not agree with the commenter. N.J.A.C. 11:3-4.7(c)8 does not identify any particular providers who cannot submit DPR requests; it merely gives insurers the ability to include such restrictions in their DPR filings. The Department reviews all such filings. Physical therapists generally submit their own DPR requests because they do an evaluation of the patient's condition, state the specific modalities recommended for treatment and set treatment goals. For PIP claims, such a request must be accompanied by a prescription from a physician.

COMMENT: Several commenters noted that proposed N.J.A.C. 11:3-4.7(c)8 would permit insurers to include in their DPR plans "reasonable restrictions" on which types of providers may submit DPR requests. DOBI's Summary asserts that while a durable medical equipment (DME) company is a "provider" as defined in N.J.A.C. 11:3-4.2, such providers do not typically determine the medical necessity for the equipment they

provide. The Summary also implies that DPR plans prohibiting a DME supplier from submitting their own request for precertification of equipment based upon a physician's prescription would be approved. The commenter stated that on a practical level, if a medical provider believes a patient needs a durable medical good, but does not provide that durable medical good, it is the durable medical goods provider who will be subject to any penalty, not the treating provider.

Another commenter noted that N.J.A.C. 11:3-4.2 includes "providers of . . . durable medical goods" within the definition of "health care provider." In the past, DOBI has been critical of distributors of medical equipment executing APTPs and participating in the precertification process because they do not make medical decisions and are not necessarily accountable pursuant to the New Jersey Insurance Fraud Prevention Act. However, the criticism is misplaced. Any documentation, including notes, prescriptions, etc. is incorporated by reference into the APTP. Where those documents contain an insurance fraud prevention warning signed or attested to by the physician, the request has the same effect as coming from the physician. Further, it is inherently unfair to bar a DME company's access to DPR yet mandate that the same provider must abide by the internal appeals provisions of the insurer's DPR plan.

Preventing a DME supplier from submitting its own request for precertification would be inequitable because the proposed changes would require a physician prescribing medical equipment to complete the required forms to submit a request for precertification for treatment under a DPR plan. A DME supplier's ability to get equipment approved and paid for should not be reliant upon a physician's diligence in completing and submitting DPR plan forms properly to the insurer. Another commenter objected to this provision

because it is improper to restrict any providers from being able to request pre-certifications.

RESPONSE: The Department does not agree with the commenters. As noted above, the adopted amendments and new rules do not prohibit DME providers from submitting an Attending Provider Treatment Form (APTF). The adopted amendments merely permit insurers to include such restrictions in their DPR plans. Such restrictions will have to be submitted to the Department for approval as part of an insurer's DPR plan with an explanation of how the insurer intends to handle requests for DME. The Department does not agree that the inclusion of a prescription or documentation signed by the physician in support of the DME with an APTF from a DME provider is sufficient. If the insurer has questions or needs more information about the medical necessity of the item of DME, the DME provider will have to contact the physician. This would make the precertification process more complicated and could possibly be used to perpetuate fraud. While DME providers may not wish to be dependent upon a physician's diligence in providing the necessary support for a DME prescription, that is the reality of the situation. A DME provider has no medical expertise to determine whether an item of equipment is medically necessary for a particular patient.

COMMENT: One commenter stated that N.J.A.C. 11:3-4.7(c)8 should be clarified to prohibit providers who cannot submit DPR requests from filing appeals on the denial of the request.

RESPONSE: The Department agrees that rules governing the internal appeal process should make it clear that, as noted below in response to other comments, providers who

cannot file decision point or precertification requests also cannot file internal appeals from denials of such equipment. Any such internal appeals would have to be filed by the providers who made the determination that the equipment or device was medically necessary. As noted below in response to other comments, the Department has determined that the internal appeal process needs to be amended in consultation with the insurers and providers. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department is adopting the rule with a 365-day delayed operative date that will allow time for amendments to be proposed, commented upon, and adopted.

COMMENT: One commenter stated that reducing the reimbursement rate to DME suppliers for TENS or EMS units and preventing DME suppliers from precertifying the products they sell will cause this DME company to go out of business. Almost immediately after the proposed changes are adopted, the commenter asserted that the company will lay off half of its staff, increasing unemployment rolls, and decreasing the amount of revenue paid in taxes to the State of New Jersey and the Federal government. In a finite amount of time, the remaining workers will be laid off. Every year, insurance companies add more requirements in order for DME suppliers to get paid, increasing the amount of paperwork, follow-ups, phone calls, certified letters, etc. When the insurer's requests are complied with, the TENS or EMS unit request is denied (about 97 percent of the time). When that occurs, the DME supplier must request an appeal, followed by a second level of appeal. The commenter stated that it can take years before payment is received on a claim. With all of the reductions to fees and services in the PIP Fee Schedule, there is never a decrease in the cost of automobile insurance. There are more

and more auto insurance commercials on TV than ever before and huge billboards on the highways; business is good for the insurance industry in New Jersey. The commenter asked why the proposal should crush small businesses that provide services for people involved in auto accidents and who are uninsured or underinsured? Where is the benefit for society with more reduction of goods and services when rates are constantly going up? Rates go up, services go down, and the injured are prematurely cut off from care.

Every dollar spent for treatment to the injured through small businesses such as medical doctors, chiropractic physicians, acupuncturists, MRI facilities, DME companies, pharmacies, etc. generates hope for the injured. It also generates a lot of commerce and creates thousands of jobs for physicians and their staffs. Hypothetically, if the insurance industry were to pay a trillion dollars per year to this small business, approximately one-third of that would be paid to the State and Federal governments through a variety of taxes. If the auto insurers were to get their way and save these hypothetical trillion dollars, the State and Federal governments would not get nearly the amount that small business pays because of the extremely different tax laws that the insurance industry has for them. Monies that would be paid in taxes by small business would be put into funds for future disasters that may never happen, etc.

There is no legitimate basis for singling out these particular commonly prescribed devices. The result will be an unfair effect on both the equipment provider and the injured victim. The argument that these two devices are excluded from the Medicare reimbursement rate because an EMS unit is available for $200.00 on the Internet does not consider the significant costs and overhead incurred by the equipment supplier.

RESPONSE: The Department does not agree with the commenter. As noted above in response to other comments, the Department's goal is give insureds the maximum PIP benefit for their claim dollar, not to support a particular business. Prescribing EMS and TENS units has been identified as being subject to overutilization. If EMS and TENS units are readily available at prices lower than those on the Medicare fee schedule, it benefits the patient who really needs one to be able to get the devices for a lower cost. The Department notes that many of the Internet sites offering the devices at lower cost are maintained by the same suppliers who charge substantially higher prices to insurers for the same device, and such lower prices logically skew the reasonable and prevailing fees for such devices downward.

N.J.A.C. 11:3-4.7A

COMMENT: One commenter maintained that the proposal does not require that review doctors function independently from either the treating doctor or the third party who will pay the bill. The commenter believes that the proposal is a good first step but urges the Department to promulgate rules that require the independence of review doctors and include specific provisions that describe what functions must be performed and documented by reviewers as part of their review. The commenter suggested that the Department should consider maintaining a registry of independent reviewers hired by third party companies and require training through the Department and yearly disclosure of any financial relationships with insurers.

RESPONSE: The Department agrees in part with the commenter. Rather than promulgate rules that require the independence of review doctors, the Department

believes that N.J.A.C. 11:3-4.7A(f) already addresses this issue by requiring as part of the registration process that PIP vendors who perform independent medical reviews provide their criteria for selection, quality control, and avoidance of conflicts of interest for doctors that conduct reviews. The Department does not agree with the commenter that the Department should maintain an independent registry of independent reviewers. The Department has no regulatory or statutory authority to maintain such a list of independent review physicians. It is the responsibility of insurers and PIP vendors to contract with doctors who are qualified and do not have conflicts of interest.

COMMENT: One commenter stated that the changes to the PIP vendor registration are advantageous to both patients and the providers who serve them.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter suggested that the Department establish penalties for not filing and failure to perform**.**

RESPONSE: The Department does not agree with the commenter that additional penalties are necessary. The rule already provides for the suspension or revocation of a PIP vendor registration.

COMMENT: One commenter requested that the term "medical director" in N.J.A.C. 11:3-4.7A(d) be amended to indicate that the medical director may be a chiropractic physician licensed in New Jersey. The commenter also requested that the statement be amended to reflect that accreditation by URAC in other modules such as Workers' Compensation Utilization Management, Independent Review Organization, or Core Standards is acceptable.

RESPONSE: The Department does not agree with the commenter. The reference to the PIP vendor's medical director was recodified from N.J.A.C. 11:3-4.7(c)1 without significant change. The Department continues to believe that the medical director of a PIP vendor should be should have the broadest medical training and scope of licensure. The Department notes that N.J.S.A. 45:9-14.5 limits the types of treatment that chiropractors can perform. PIP vendors can and do also employ chiropractors to work under the medical director. With regard to PIP vendors having accreditation in other URAC modules, an applicant to be a PIP vendor can certainly include that information in its application. The Department will review the other URAC modules and determine if it is appropriate to name them in the rule text through future amendments.

COMMENT: One commenter noted that there is no requirement that doctors, other than the medical director who perform peer reviews and/or IMEs, be licensed in New Jersey, which seems to be a violation of various licensing boards' regulations.

RESPONSE: The Department does not agree with the commenter. The adopted new rules and amendments govern reimbursement for claims under the PIP coverage of the auto insurance policy. Persons who provide services covered by PIP coverage are also subject to many licensing and other requirements that are not included in these rules.

COMMENT: One commenter requested clarification as to whether the term "MCO" in N.J.A.C. 11:3-4.7A(d) meant the same as WCMCO as that term is defined in N.J.A.C. 11:3-4.2.

RESPONSE: The term "MCO" is not used in the proposal. The commenter is referring to language in the Summary of the proposal, which is not part of the rule, and the adopted

rule language controls. N.J.A.C. 11:3-4.7A(d)6 states that, "A statement about whether the applicant is licensed or certified as an entity that has networks as that term is defined in N.J.A.C. 11:3-4.8(a) or accredited by nationally recognized accrediting agencies such as URAC (http://www.urac.org/) in Health Utilization Management."

COMMENT: One commenter noted that it provided bill management for insurers to facilitate application of the fee schedule guidelines and pricing. The commenter also works with several managed care organization partners and provides software to support managed care decisions. The commenter asked if it was required to register as a PIP vendor.

RESPONSE: The Department is unable to respond to this question in the comments and responses to the rule. When the rule is adopted, the commenter should contact the Department with a more detailed description of the services it performs for insurers and the Department will determine whether it needs to register as a PIP vendor.

COMMENT: One commenter inquired what detail is required in sharing workflows and detailed flowcharts pertaining to utilization management required by N.J.A.C. 11:3-4.7A(e)1. The commenter indicated that it does not feel that sharing this information is appropriate, and notes that there are no specifications surrounding OPRA requests nor are there any protections within the rule.

RESPONSE: The Department does not agree with the commenter. The Department believes that information about how the vendor handles its workflow is important to demonstrating that it has the knowledge and systems necessary to handle PIP utilization management for an insurer. The Department also notes that all information submitted

with an application to be a PIP vendor is confidential except for designated exceptions that do not apply to this information pursuant to N.J.A.C. 11:3-4.7A(l).

COMMENT: One commenter referenced N.J.A.C. 11:3-4.7A(e)3, which states that a PIP vendor seeking registration must describe its methodologies for detecting "underutilization" of services. The commenter noted that there is no other reference to "underutilization" in the rule and no guidance as to what action is required when "underutilization" is detected.

RESPONSE: The Department does not believe that clarification of the rule is necessary. Underutilization refers to the failure to use lower cost, less invasive modalities before higher priced, more invasive alternatives are requested.

COMMENT: One commenter requested that the Department amend the rule upon adoption to include a streamlined PIP vendor registration process for a certified WCMCO that seeks to become a PIP vendor. The commenter believes that requiring a separate registration process for WCMCO's that have already been approved by the Department is duplicative and unnecessary.

RESPONSE: The Department does not agree with the commenter. Since worker's compensation is directed care, which is significantly different than PIP, it is important for the Department to be sure that a WCMCO that wishes to be a PIP vendor have the resources and expertise necessary to handle PIP utilization management.

COMMENT: One commenter asked that the Department confirm that URAC accreditation is not a prerequisite for a registration as a PIP vendor. The commenter also asked if the Department intends to make URAC accreditation mandatory and, if so, how

much advance notice would the Department provide.

RESPONSE: URAC certification is not a prerequisite for registration as a PIP vendor. The Department has no immediate plans to make such a certification mandatory. If it decides to do so, it would require an amendment to N.J.A.C. 11:3-4.7A, which would give interested parties ample notice and an opportunity to comment.

N.J.A.C. 11:3-4.7B

COMMENT: Several commenters commended the Department for attempting to make the internal appeals process standardized in the hope of streamlining the process and noted that all stakeholders will benefit from the uniform internal appeal process.

RESPONSE: The Department appreciates the support.

COMMENT: Several commenters declared that the internal appeals procedures amendments establish a new process that creates barriers to patient care, thereby making it more difficult to obtain needed treatment. The five business days for physicians to appeal adverse insurer decisions should be expanded since the work involved in an appeal is largely on the physician's practice. The rules should make clear that the internal appeal procedures do not apply to insureds. Several commenters suggested that at a maximum, carriers should be given five business days to respond because it is detrimental to the patient's well-being to have to wait 10 business days for the insurer to respond. One commenter noted that both treatment and administrative appeals should look to the date of receipt for measuring timeliness of appeal. In addition, the physician should be allowed to re-request the treatment without penalty. Under the proposed language, the right to arbitrate can be lost if the deadline is missed. Several commenters

objected to the provision that allows physicians to be penalized for untimely treatment appeals. One commenter urged the Department to create an exception to the internal appeal requirement for an additional PIP medical exam for emergent situations, to avoid immediate and irreparable harm to the patient. Several commenters stated that the proposed rule exceeds the Department's authority since the No-Fault Act does not grant the Department the authority to penalize doctors and lawyers who fail to comply with procedural requirements. While PIP carriers may include an optional internal appeal in its DPR plan, the statute does not allow for a mandatory internal appeal process for DPR disputes, nor a mandatory internal appeal process for issues outside the DPR plan such as fees, non payment, etc.

RESPONSE: The Department agrees with the commenters that some parts of the internal appeal process need to be changed. Many parts of the internal appeal process to which the commenters objected were included because the Department believes that some providers do not consider the process to be a simple and rapid way to resolve disputes, but as a hurdle to be met or evaded to take disputes to costly arbitration.

The five-day deadline for providers to submit treatment appeals was not intended to be a statute of limitations. The short deadline was designed to get decisions on future treatment back to the provider as quickly as possible to benefit the patient. If, as the comments indicate, five days is too short a time, the deadline can be lengthened when the Department proposes amendments to the rule.

The Department does not agree that it does not have the authority to establish a uniform, mandatory internal appeal process. As repeatedly affirmed by the Appellate Division in

challenges to prior PIP rule adoptions, the Commissioner has broad statutory authority under N.J.S.A. 39:6A-4 and the expertise to implement processes and protocols and adopt fee schedules to ensure the provision of all reasonable, necessary, and appropriate medical treatment for insured under the PIP provisions of auto policies. See *In re Adoption of N.J.A.C. 11:3-29; Coalition for Quality Health Care, et al. v. NJ Dep't of Banking and Ins.* ("*Coalition III*"), 358 *N.J. Super*. 123, 131 (App. Div. 2003); *In re Failure to Adopt 861 CPT Codes*, 358 *N.J. Super.* 135, 149 (App. Div. 2003); *Coalition I*, *supra*, 323 *N.J. Super.* at 229 (App. Div. 1999), *certif. denied*, 162 *N.J.* 485 (1999). N.J.A.C. 11:3-4.7(c)6 currently requires that insurers have an internal appeals process as part of their DPR plans, and the inclusion of a uniform internal appeals procedure falls within the Commissioner's authority to require DPR plans. Further, the Department has approved restrictions on the assignment of benefits that require that the provider follow the insurer's internal appeal process prior to going to arbitration, and issued Bulletin No. 10-30, which further notes this ability. The proposed amendments simply make this existing process uniform and therefore easier for providers to use.

As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with insurers and providers. Any such amendments would constitute substantial changes requiring additional notice and opportunity for comment. So as not to delay the process of reforming the other components of the PIP system that were subjects of the proposals, the Department is adopting the amendments to N.J.A.C. 11:3-4.7B with a 365-day delayed operative date that will allow time for amendments to be proposed, commented upon, and adopted before the delayed amendments go into effect. If necessary, the Department can extend the delayed operative date further.

COMMENT: Several commenters stated that the proposed internal appeals procedure was limited to providers filing under an assignment of benefits. One commenter stated that the internal appeals process gives power to insurance companies while consumers and their doctors have half the time to review important documents. The commenter queried whether doctors will want to treat auto accident victims in light of "all the red tape." The commenter requested that the procedure be expanded to include claimants, noting that the procedure is designed to ensure that a party submitting a claim under a PIP policy has the ability to question an adverse decision and submit additional information to clarify his or her position. One commenter pointed out that the health insurance process upon which the Department based the PIP appeal procedure is mandatory for all claimants. Another commenter noted that the Florida Supreme Court has ruled that a different procedure for provider and insured appeals is unconstitutional.

RESPONSE: The Department does not agree with the commenters. The internal appeal procedure, along with all of the requirements for filing DPR requests, are designed to be used by providers acting on an assignment of benefits. It is the treating provider who has the necessary information about the medical necessity of treatments. Further, New Jersey law is different to that in Florida and the Department is not governed by Florida judicial decisions. However, as noted above in response to another comment, the Department has determined to adopt N.J.A.C. 11:3-4.7B with a 365-day delayed operative date and to propose amendments to the process.

COMMENT: Several commenters requested an opportunity to review and comment on the appeal form to be developed by the Department. One commenter provided a form that would contain the necessary information for an appeal. Another commenter urged

that there should be training sessions for providers and payors, that the form should detail the documentation necessary for an appeal, that providers and payors should be allowed adequate, equal time to submit and respond to the appeal, and that it should be required that the provider present all documentation related to the appeal at the time of initial appeal. One commenter urged the Department to require insurers to participate in outreach and training on the new uniform internal appeal process so that the kind of delays that were experienced when the Health Claims Authorizing, Processing, and Payment Act (HCAPPA) process was first rolled out are not repeated.

RESPONSE: The Department agrees with the commenters that insurers and providers be given an opportunity to review and comment on the form to be used for internal appeals. The Department also agrees that outreach education efforts on the process are a good idea. As noted above in response to another comment, the Department has determined to adopt N.J.A.C. 11:3-4.7B with a 365-day delayed operative date to be able to propose amendments to the process.

COMMENT: One commenter noted that the provider appeals process and dispute resolution system are advantageous to both patients and providers.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter stated that in order to further the objective of preventing fraudulent practices and increasing the value of the PIP benefit to the injured person, the Department should monitor the internal appeals program of each of the carriers to determine how many internal appeals are filed, how many are granted and how many are denied. The commenter noted that by allowing the opportunity for carriers to reverse

unreasonable denials without immediate access to the PIP dispute resolution process, and without statistical reporting requirements, carriers have incentives to delay and deny needed treatment without fear of any negative ramifications.

RESPONSE: The Department agrees with commenter to the extent that it intends to monitor the implementation of the internal appeal process carefully when it becomes operative. However, the Department does not agree that the implementation of any internal appeals process will encourage insurers to deny precertification and DPR requests arbitrarily in order to delay and deny needed treatment. Rather, the Department believes that a uniform appeals process will enable efficient and prompt review of initial denials by insurers and timely reversals where the requested medical treatment is found to be reasonable, necessary, and appropriate under the Department's rules and the provisions of N.J.S.A. 39:6A-4.

COMMENT: One commenter inquired why N.J.A.C. 11:3-4.7B(a) is limited to a provider who has an assignment of benefits or power of attorney. The commenter indicated that even if the provider had neither of these, there is no reason that he should not be allowed to appeal the decision.

RESPONSE: The Department does not agree with the comment. A provider may only appeal decisions and receive payment directly from the insurer if he or she has been assigned benefits by the insured or has a power of attorney from the insured. Otherwise, it is the insured who has the contract with the insurer, who receives payment for benefits and can appeal decisions.

COMMENT: One commenter stated that if it is the Commissioner's desire to require that

appeals be exhausted, then a requirement for additional documents cannot be included because a proper request would have included all the documentation in the first instance.

RESPONSE: The Department does not agree with the commenter. If an insurer receives an appeal and determines that additional documents are necessary, it can request them. As currently drafted, failure to produce the requested documents means that the appeal is denied as incomplete, and the Department anticipates that the amendments to the internal appeals process will provide a similar procedure.

COMMENT: One commenter noted that several aspects of the rule proposal require carriers to file new policy forms and new DPR Plans that would include the proposed new appeal procedures. The commenter sought clarification whether these new appeal procedures go into effect when the carrier amends its policy and DPR plan or whether the new appeal procedures go into effect as of a date certain even if the amended policy forms and DPR plan of a particular carrier have not yet been filed and approved.

RESPONSE: As noted above in response to earlier Comments, the Department has determined to adopt the new rules but with a 365-day delayed operative date that will allow for amendments to be proposed after consultation with interested parties. Part of that process will include timelines for how and when the new appeal procedures will go into effect.

COMMENT: One commenter stated that this section should be revised to permit the OSF that employs or contracts with the provider to file a first-level appeal with the insurance carrier. The ability to file such an appeal should not be limited to the provider or the insured's power of attorney. In addition, the commenter noted that the proposal

requires proof that the internal appeals process is utilized prior to proceeding to arbitration. In order for the internal appeal followed by arbitration process to remain consistent, the OSF should be permitted to file an internal appeal separate from the provider and/or the insured's power of attorney.

RESPONSE: The Department does not agree that any change is necessary. N.J.A.C. 11:3-4.2 defines "health care provider" very broadly and such definition includes hospital outpatient facilities. As stated in the Response to a previous Comment, a provider may only appeal a decision and receive payment directly from the insurer if he or she has been assigned benefits by the insured. Otherwise, it is the insured who has the contract with the insurer, who receives payment for benefits and can appeal decisions.

COMMENT: One commenter requested clarification as to whether the term "provider" as used in N.J.A.C. 11:3-4.7B(a), describing who can file internal appeals, includes "secondary providers" as defined by N.J.A.C. 11:3-25.1.

RESPONSE: The definition and use of the term "secondary provider" in N.J.A.C. 11:3-25.1, in the Notification by Treating Medical Providers rules, has no relation to the term "provider" as used in N.J.A.C. 11:3-4.7B(a).

COMMENT: Noting that N.J.A.C. 11:3-4.7B(b)4 included, "disputes about whether the injuries were caused by the accident," as one of the bases on which an internal appeal may be filed, one commenter stated that it had concerns over coverage and causality issues being instituted in such appeals because the issue may be of a legal or medical nature.

RESPONSE: The Department does not agree with the commenter. If an insurer denied a

DPR request or payment for a service on the grounds that the injuries were not caused by the motor vehicle accident, it would be appropriate for the provider to appeal that decision through the internal appeals process before going to arbitration or into the court system.

COMMENT: One commenter believed that the description of an "adverse decision" in N.J.A.C. 11:3-4.7B(b) was overly broad and should be clarified to indicate that issues involving coverage, eligibility, or fraudulent conduct would not be considered an "adverse decision" and would not be subject to an internal appeal by the provider.

RESPONSE: The Department does not agree with the commenter. If an insurer denied a DPR request or payment for a service on the grounds that the injuries were not caused by the motor vehicle accident or the insured was not eligible for coverage, it would be appropriate for the provider to appeal that decision through the internal appeals process before going to arbitration. The same is true for fraudulent conduct.

COMMENT: One commenter stated that N.J.A.C. 11:3-4.7B(b)6 should be clarified upon adoption to read, "disputes about the usual customary and reasonable fee as determined by reference to national databases," not the UCR defined by the provider.

RESPONSE: The Department agrees that the use of the word "provider" in this provision should be clarified but does not agree with the commenter's suggested language because determination of UCR is not limited to reference to national databases. As noted above in the Response to an earlier Comment, the Department has determined to adopt the new rule but with a 365-day delayed operative date that will allow for amendments to be proposed after consultation with interested parties. As part of that

process, the Department will consider a future amendment to N.J.A.C. 11:3-4.7B(b)6 to read (addition in boldface): "Disputes involving the [provider's] usual, customary and reasonable fee **calculated in accordance with N.J.A.C. 11:3-29.4(e)**."

COMMENT: One commenter asked if it was the intent of N.J.A.C. 11:3-4.7B(c)1 only to address future treatment. The commenter then asked how to handle appeals for treatment that was already performed. Another commenter requested that the definition of "treatment appeals" be expanded to include appeals involving the causal relationship of the accident and the need for future treatment or testing. Another commenter requested that the definition of "treatment appeals" be clarified since it appears that DOBI's intention was to apply the five-day time limitation only to appeals with respect to treatment that has not been rendered as of the time the adverse decision is received. The commenter believed that it would be preferable to specifically link the definition to the status of the treatment at the time the adverse decision is received, rather than linking it to the status of the treatment as of the time the provider submits a DPR/precertification request. A treatment appeal could be described and/or defined as "an appeal with respect to future treatment or testing for which a provider has submitted a properly completed DPR/Precertification Request and receives a medical necessity adverse decision prior to the requested future treatment or testing having been rendered." This would make it clear that in cases where a provider receives an adverse decision on a precertification request after treatment has been performed, an appeal of the adverse decision would not be a treatment appeal, but rather an administrative appeal since the service has already been provided and the patient is no longer waiting for care to be rendered

RESPONSE: The Department agrees in part with the commenter that the language could

be changed to clarify that treatment appeals are linked to the status of treatment at the time the adverse decision is received, not when the provider makes the request. The Department does not believe that any amendment of N.J.A.C. 11:3-4.7(c)1 is necessary to address appeals involving the causal relationship of the injury to the accident. The relationship of the injury to the accident is a reason that treatment request might be denied, not a separate type of appeal. However, as noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted and the language suggested by the commenter will be considered upon amendment.

COMMENT: Several commenters noted that a doctor performing a test or treatment after being denied on an initial pre-certification request but before the carrier has acted on the doctor's appeal can be subject to a 50 percent penalty by the carrier because the doctor did not wait for the appeal decision, even if the test/treatment is approved. Furthermore, if the carrier denies the appeal and an arbitrator rules the test treatment medically necessary, the carrier can still apply a 50 percent penalty. The total maximum time period allowed to the carrier could be as much as 22 calendar days from the time of initial DPR to an appeal decision while the patient waits for needed care.

RESPONSE: The Department does not understand the comment. The commenter states that the provider performed the test or treatment without waiting for a decision by the insurer and then states that the patient is waiting for needed care.

COMMENT: One commenter stated that N.J.A.C. 11:3-4.7B(d), which states all internal appeals shall be filed on a form established by the Department, is the cornerstone of the proposals and that this form, and its requirements, should be exposed to all of the relevant stakeholders before the proposals take effect.

RESPONSE: The Department did share the rule with interested parties prior to proposal and the proposal process provides notice to stakeholders before the rule takes effect; however, the Department notes that the proposed form for the internal appeal process was not included as a part of this adoption. As noted above in the Response to another Comment, the Department agrees that stakeholders should have input into the development of this form and has determined that the internal appeal process rule needs substantive amendments that cannot be made upon adoption. Therefore, the Department is adopting the rule with a 365-day delayed operative date to permit amendments to be proposed commented upon, and adopted.

COMMENT: One commenter stated that the proposed rule appears to require that an insurer provide a regular mailing address and a fax number for filing appeals, while permitting an insurer to provide an electronic means of submitting appeals. The commenter requested the ability to designate only one method of submitting appeals. This would enable uniform handling of appeal requests, which would promote efficiency and reduce expenses. Another commenter noted that the Department should require the same information from a provider on an appeal, that is, a regular mailing address and a fax number for receiving appeal responses. Several commenters stated that carriers should be required to establish a website and a procedure for submitting documents electronically. In addition, the carrier should be required to respond in the same manner

as the submission was made by the medical provider. It will be easier and less expensive to transmit records by e-mail than regular mail or fax, and the electronic means of transmittal is especially important where there is a time limit for submitting documentation**.** Another commenter urged that the provider note on the standardized appeal form if the treatment under appeal has been performed at the time of appeal. If so, then this type of appeal would be administrative and not treatment. The commenter also recommended adding an area for the provider to note the date when the adverse decision was received.

RESPONSE: The Department does not agree with the commenters that all appeals should be submitted electronically. There may be providers who do not have the ability to submit requests by e-mail and there are insurers that are not set up to accept appeals by e-mail. At least at the beginning, the Department wants to permit the most common types of transmission mechanisms, recognizing that faxing is the most common. As providers and insurers become more familiar with the process, it may be appropriate to address the issue of how appeals are transmitted. There is nothing in the rule that would prohibit an insurer from establishing a website where providers could file appeals. However, the insurer would have to also permit appeals to be made by fax and mail. The Department will consider the commenter's suggestion about what should be on the standard appeal form when it develops the form as part of future rulemaking.

COMMENT: One commenter sought confirmation that the review for medical necessity of future treatment can never be appealed through an administrative appeal, and that once treatment has been completed it is not subject to the treatment appeal process but only the administrative appeal process.

RESPONSE: The commenter is correct as the rule is currently written and the Department does not anticipate any changes to this distinction in the future amendments to the rule.

COMMENT: Several commenters recommended that this section be expanded to require that the appeal form include the necessary basis for the appeal and any additional documentation related to the appeal. One commenter believed that this would prevent the common practice of the provider simply resubmitting the documentation and calling it an appeal. This provision establishes the elements of the appeal form but does not address a critical part of any appeal: the need for the appellant to set forth in detail why the initial decision should be reversed, including all documentation to support such a reversal. The commenter also requested that all parties be presented with copies of the proposed forms and be given the opportunity to comment on them and suggest changes. One commenter noted that the appeal form must reference the correct insurance claim number; the problem is that the insurance company often provides an incorrect number.

RESPONSE: The Department notes that the appeal form has not been developed. As noted above, the Department agrees users of the process should have input into the development of the form as part of the amendment to be proposed to the rule.

COMMENT: One commenter stated that the proposed revisions to N.J.A.C. 11:3-4.7B(d)3, 4, and 5 mandate that it is the sender's responsibility to provide proof that the item was mailed, thereby creating a costly requirement that providers must send appeals by certified mail.

RESPONSE: The purpose of the proof of mailing requirement was to prevent

unscrupulous providers from falsely claiming that an appeal was submitted to which the insurer did not respond before the deadline. Such a provider could then take the matter to arbitration. As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter expressed a concern with the requirement in N.J.A.C. 11:3-4.7B(d)5 that the postmark provide the date of mailing for appeals, acknowledgments, and decisions. The commenter stated that insurers and/or vendors who send mail in large volume or use mail vendors to place mail in the U.S. Postal Service will experience extreme difficulty in determining a postmark date for any particular letter. The commenter suggested that the rule be amended upon adoption to create a presumption that a postmark date is the date on which an insurer, vendor, or mail vendor places properly stamped and addressed mail with the U.S. Postal Service.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter requested that, in the interest of fairness, all parties should

be required to accept fax confirmations, not just insurers. The commenter suggested the following alternate language with new text bolded:

N.J.A.C. 11:3-4.7B(d)4 - A confirmation generated by fax machine or computer that shows the time, date and fax number of the sending and receiving machine shall be evidence that the appeal, acknowledgement or decision was faxed and received. **All parties** must accept fax confirmations.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: Several commenters requested that N.J.A.C. 11:3-4.7B(d)4 and 5 and (e) be amended to provide more clarity concerning when an appeal, acknowledgment, and/or decision are deemed "served" for purposes of starting the clock on response times. One commenter suggested the following revisions with new language bolded and deletions in brackets:

N.J.A.C. 11:3-4.7B(d)4 - A confirmation generated by a fax machine or computer that shows the time, date, and fax number of the sending and receiving machine shall be evidence that the appeal, acknowledgment or decision was [faxed and received] **served**. The insurer **and the provider** must accept fax confirmations:

N.J.A.C. 11:3-4.7B(d)5 - For appeals, acknowledgments and decisions sent by

regular mail, the postmark date shall be considered as the date the appeal, decision or acknowledgment was [mailed] **served**.

N.J.A.C. 11:3-4.7B(e) - A treatment appeal shall be [submitted] **served** no later than five business days after [the provider has received notice of] **the insurer has served** the adverse decision that is the basis for the appeal**.**

Several commenters also suggested adding a new paragraph, N.J.A.C. 11:3-4.7B(d)6, which would provide a mailbox rule provision, consistent with that used in the New Jersey Court Rules for appeal communications that are mailed. One commenter noted that starting the clock on receipt of appeal documents only works for facsimile transmissions. The sender has no way of knowing when documents sent by regular mail are received. Another commenter stated that absent a mailbox provision, insurers and vendors would be required to send letters via certified or registered mail so as to confirm a receipt date and this would be contrary to the Department's goals to contain costs. Another commenter recommended that it should be the date of issue of an acknowledgment or response by the carrier, rather than the date the provider claims to receive either of these documents, that should be utilized. The commenter stated while a carrier may not be able to prove exactly when the provider received a document, it can definitely provide evidence of when it issued the document.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to

adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter noted that pursuant to N.J.A.C. 11:3-4.7B(d)2, appeals that are lacking required information must be acknowledged by the insurer as "incomplete." The commenter questioned whether the provider can cure the deficiency and resubmit the appeal. The commenter also noted the requirement that insurers acknowledge untimely appeals as "late." The commenter asked whether this notification of a late appeal needs to be made within the time frame required for acknowledgment of timely appeals. Another commenter suggested that the appeal form must include any existing medical documentation submitted to support the request for more treatment and require that any existing medical documentation be submitted as part of the appeal or it shall not be considered by the DRP in any subsequent arbitration filing. Another commenter stated that there is no independent review on the issue of whether an internal appeal is late or incomplete; it is solely determined by the insurance carrier and that this is just not fair. Another commenter inquired whether a provider is barred from filing arbitration if it submits an "incomplete" appeal and supplies no further information; the commenter also inquired what penalty applies to a carrier who fails to respond to an "incomplete" appeal.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenters' concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments

to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter noted that N.J.A.C. 11:3-4.7B(d)2 sets forth the information that has to be included on an appeal form. The commenter suggested that additional information needed to be provided including: the provider's address if the appeal is sent by regular mail, the provider's fax number if the appeal is sent by fax and the provider's e-mail address, if the appeal is sent electronically. The commenter also recommended that if the above information was missing, the appeal should be considered incomplete and returned to the provider.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenters' concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter noted that the proposal requires that if filing an appeal the provider shall, "clearly identify the adverse decision that is the basis for the appeal…" The commenter stated that there can be multiple issues in an appeal from fee schedule reductions to National Correct Coding Initiative (NCCI) edits and asked if providers will be required to state the specific codes and payments that are in question and the reason why.

RESPONSE: The Department believes that it is to a provider's benefit to be as specific as possible in stating the adverse decision that is the basis for the appeal. This will ensure

that the insurer can respond correctly.

COMMENT: One commenter observed that while N.J.A.C. 11:3-4.7B(d)4 requires that appeals must be submitted to the designated fax number, the rule does not state definitely that something sent to an incorrect fax number is considered null and void. The commenter requested that the rule be clarified to state that an appeal sent to a fax number or mail address not designated in the insurer's DPR plan need not be considered or responded to by the insurer or vendor. Similarly, the commenter asked whether there is a requirement to review or respond to any submission that is not on the form set forth by Department Order. Several commenters also suggested that there needs to be additional information on the fax confirmation sheet that demonstrates what and for whom the fax material was related. The commenters stated that a fax confirmation sheet that simply has the date, fax number, and time is insufficient to demonstrate what material was faxed and ought to include the patient name and claim number. One commenter believed that as written, the proposal might enable those so inclined to commit dishonest acts by providing fax covers where no substantive appeal was filed.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenters' concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter asked that language be added to N.J.A.C. 11:3-4.7B(d) to

clarify that the required address and fax number of the insurer be extended to include an "insurer's designee." The commenter also requested that this clarification be applied to the requirement that insurers acknowledge receipt of appeals. Another commenter noted that a carrier is required both to acknowledge the appeal within a certain period of time and then also respond within a certain time period. The purpose of having a two-step process is not apparent to the commenter, who observed that, from the carrier's perspective, the two-step requirement means that there are two chances to make a mistake. The commenter suggested that the requirement for acknowledgment be eliminated. The commenter also stated that the penalty imposed upon the carrier for failing properly to both acknowledge and respond to the appeal is disproportionate both to the offense and the penalty imposed on a provider who fails to timely appeal. The commenter indicated that there is a loophole in the proposal since a provider who fails to appeal properly cannot bring an action himself to have a procedure paid for, but the patient can still file an action himself and have the procedure paid for. The commenter urged that this practice occurs now, and therefore the proposal should be modified in one of two ways: if the carrier fails to comply with the appeal requirements, then the penalty should be the loss of the right to argue that the provider cannot bring the action directly to get the procedure paid for; alternatively, since it is the provider who can only really appeal a pre-certification denial, the rule should be that if the provider fails to appeal properly, neither the provider nor the patient can bring an action to get the procedure paid for and the provider would not be able to bill the patient for the services that were not appealed.

RESPONSE: The Department does not believe that any clarification is necessary

regarding the "designee" issue. The definition of insurer in N.J.A.C. 11:3-4 states that, "For the purposes of communicating with insureds or providers concerning the administration of DPR plans, 'insurer' also means the insurer's PIP vendor." However, as noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenters' concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter noted that N.J.A.C. 11:3-4.7B(d)4 requires that fax confirmation sheets shall be evidence that an appeal, acknowledgement, or decision was faxed and received. The commenter suggested that additional information, such as the insurer's claim number, date of loss, and name of insured person, must also appear on the fax confirmation sheet and stated that this was easily achieved by putting this information on the top half of the faxed document. A fax confirmation sheet incorporates the top half of the cover sheet or first faxed page.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: Several commenters believed that the five-day appeal deadline in N.J.A.C. 11:3-4.7B(e) for treatment appeals was too short and suggested that it ought to be lengthened, for example, to 30 days, 13 days, or at least 10 days from the mailing of the adverse decision, etc., to take into consideration a solo practitioner who needs to juggle numerous pre-certifications, referrals or prescriptions; or any provider who is out of the office, or unable to work because of a natural disaster or emergency. It was suggested that a "good cause" or "substantial compliance" provision could be included which would allow for an extension of time in circumstances or situations beyond the provider's control where a timely appeal cannot be made. Several commenters characterized this provision in terms of the PIP statute of limitations and noted that the current two year time period in which to appeal any medical necessity denial has been reduced to five days according to this provision and that this is unreasonable, unconscionable and ultra vires because it is in direct conflict with the PIP statute. The commenters also described the five-day timeframe as arbitrary, capricious, and unreasonable. The two-year statute of limitations in the No-Fault Act does not impose any preconditions for filing a suit; however, the proposed regulation does, because it bars access to the dispute resolution mechanism of the statute unless the internal appears process is exhausted.

RESPONSE: The Department does not agree with the commenters. The commenters are referring to the statutory two-year statute of limitations found in N.J.S.A. 39:6A-13.1, which refers to a limitation on filing actions in Superior Court. As there is no restriction on providers filing suits in Superior Court in the rule, the deadlines for the internal appeal process does not conflict with N.J.S.A. 39:6A-13.1. As noted above in the Response to another Comment, the five-day deadline for providers to submit treatment appeals was

not intended to be a statute of limitations. The short deadline was designed to get decisions on future treatment back to the provider as quickly as possible to benefit the patient. If, as the comments indicate, providers want more time to file appeals, the deadline can be lengthened as part of the amendments to this provision referenced below.

As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: Several commenters suggested that the denial of treatment appeals be submitted to a separate "intermediate track" where disputes must be resolved within 60 days from the date that the demand for arbitration is filed. It is inequitable to force the patient to seek relief from an adverse decision through the current PIP arbitration system where the hearing will not occur for at least 12 months.

RESPONSE: The Department does not agree with the commenter. In response to requests for an arbitration "intermediate track," the Department amended N.J.A.C. 11:3-5.4(b)6 in 2009 to require the arbitration administrator to establish a procedure for an expedited review of medical necessity by an MRO. Using this procedure, a patient can get a medical necessity decision on future treatment or testing within 35 days.

COMMENT: One commenter noted that a provider that fails to submit an appeal within the deadlines in the proposal may simply submit a new DPR request to restart the process without any penalty. Several commenters suggested that if a provider misses the deadline

to submit a treatment appeal, he or she should only be able to submit one additional DPR request for the same treatment or testing that was denied absent changed circumstances. Several commenters stated that this provision could create a never-ending cycle of DPR requests and litigation about timeliness, resulting in increased costs. Another commenter stated that the provision should be clarified to note that the resubmission of a DPR request in those instances of a missed treatment appeal(s) does not have to occur prior to the treatment having been performed. In other words, if a DPR request is submitted and denied by the carrier, and the appeal time frame is missed, then the provider must submit a new request and subsequent appeal only prior to instituting arbitration, as opposed to performing the treatment. Further, once an issue in dispute is appealed properly the matter is preserved for arbitration. Another commenter noted that the proposed process creates the likelihood that a provider will simply submit multiple DPR requests for the same treatment and hope for one default by the carrier. If a carrier misses one treatment appeal, it loses the applicable defense on medical necessity. Another commenter did not understand why providers should be given a second chance to file a treatment appeal. This commenter believes that the deadlines in N.J.A.C. 11:3-4.7B should apply equally to all parties. One commenter suggested that the proposal be amended to clearly state that if the carrier mishandles the appeal, it is only foreclosed from challenging the medical necessity of the requested treatment/testing in any subsequent arbitration, but could continue to defend the claim on any and all other grounds regardless of what issues were actually raised in the provider's appeal. The current proposal prevents the carrier from challenging any issue raised in the appeal, and should be amended to clarify that only the medical necessity defense is lost if the carrier mishandled the appeal.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter stated that there will be confusion and disputes concerning whether an appeal should be considered a treatment appeal or an administrative appeal. Given the disparate time frames for each appeal, combined with the serious penalties imposed on the carrier who fails to properly respond to an appeal, the commenter suggested that the two definitions be eliminated and establish one category of appeal from which providers would appeal adverse determinations, defined as any determination by the insurer with which the provider does not agree. This approach would avoid a number of issues, such as those that would arise in a situation in which a secondary provider who performs services seeks reimbursement. Typically a secondary provider such as an anesthesiologist does not himself seek pre-certification of the procedure, so if the carrier denies the pre-certification request of the treating provider, is the anesthesiologist's appeal a treatment appeal or an administrative appeal? If the two proposed types of appeals are available, then the commenter states that the Department needs to clarify if an appeal by a secondary provider is a treatment or administrative appeal.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the

commenter's concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter requested clarification of the language that bars a provider from filing an administrative appeal after performing treatment or testing that was denied by the insurer under a DPR plan request if the provider did not appeal the original denial.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter noted that there is an error in the Summary. The Department states that "an insurer has no obligation to reimburse a provider for treatment that was not medically necessary" and can impose a 50 percent copayment "on treatment that has been determined to be medically necessary but was performed when a DPR request was required and was either not made or was denied." The commenter believes that this is a misstatement of the proposal. The Department is correct that a carrier can impose a copayment penalty if a DPR request was not made and treatment has later been determined to be medically necessary. However, the proposed rules do not permit a carrier to impose a penalty if the DPR request was denied.

RESPONSE: The Department agrees with the commenter that the Summary is incorrect but notes that the Summary is not part of the rule.

COMMENT: One commenter asked if a provider does not submit a treatment appeal within five days and then submits another DPR request, can the second review apply retroactively to all the treatment rendered since the submission of the initial decision point request or just to treatment rendered after the initial request?

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter stated that N.J.A.C. 11:3-4.7B(e) is not clear on how to handle requests that contain both treatment appeals and administrative appeals.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: Several commenters requested that resubmissions of DPR requests after providers missed the treatment appeal filing deadline should be clearly marked as

duplicates and the insurer's failure to respond to a duplicate request would not result in the loss of the right to raise defenses as provided in N.J.A.C. 11:3-4.7B(k). The commenter requested confirmation that insurers may build additional penalties and requirements into their DPR plans to deal with duplicate submissions. Another commenter recommended that the proposal be amended to state that a resubmitted DPR request that does not contain any substantive additional information in support of the appeal does not satisfy the requirements for an appeal and does not require a response by the insurer.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenters' concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

N.J.A.C. 11:3-4.7B(g)

COMMENT: Following up on other comments, one commenter requested that N.J.A.C. 11:3-4.7B(g) be amended as follows (addition in boldface):

"An administrative appeal shall be submitted within 180 days **of service** of the adverse decision that is the basis for the appeal."

The commenter also believed that 30 days was a more appropriate deadline for submission of administrative appeals. The commenter stated that the 180-day deadline would unnecessarily delay disputes that will ultimately go to arbitration. Another

commenter stated that it was not clear when this 180-day period starts. Other commenters believed that 60 days was a more appropriate deadline for the submission of administrative appeals. Another commenter suggested a 90- or 120-day appeal deadline, noting that this would allow the provider to submit one appeal for the whole treatment. The commenter stated that the vast majority of PIP treatments are completed in less than 90 days. The commenter stated that a significantly shorter appeal deadline would force providers to submit appeals for every bill, which is not cost effective and longer appeal deadlines would mean that claim files sit open longer than is necessary. The commenter also urged the Department to amend the rule upon adoption to state that if the provider does not meet the administrative appeal deadline, the appeal should be denied and the provider should not be allowed to file for arbitration. Another commenter urged the Department to change the "shall" to "must" to further clarify the timeframe for submission.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenters' concerns as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter stated that the proposed regulation requires providers to jump through significant hurdles within 180 days of receiving notice of an adverse decision or forfeit the ability to bring an action for PIP benefits payment within the two year statute of limitations. The commenter claimed that this creates an ultra vires,

internal statute of limitations which, if not satisfied, acts as a bar to rights afforded under the No-Fault Act.

RESPONSE: The Department does not agree with the commenter. The commenter is referring to the statutory two-year statute of limitations found in N.J.S.A. 39:6A-13.1, which refers to a limitation on filing actions in Superior Court. As there is no restriction on providers filing suits in Superior Court in these rules, the deadlines for the internal appeal process does not conflict with N.J.S.A. 39:6A-13.1.

COMMENT: One commenter inquired how to handle PPO contracts with shorter deadlines for filing disputes. This provision might be construed to extend such deadlines beyond the contractual terms.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenters' concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

N.J.A.C. 11:3-4.7B(h) - Acknowledgment of Appeals

COMMENT: One commenter stated that it did not believe that the acknowledgments of appeals are necessary except in cases where they are incomplete or late. The commenter recommends removing the requirement from the rule upon adoption. The commenter also stated that if the Department does not agree that the acknowledgment requirement should be removed, it should be amended to permit telephonic acknowledgment, perhaps

with a requirement for a written follow-up. Another commenter suggested simply requiring each side to serve the other by self-proving means (fax, e-mail, courier) and use the date of service as the triggering date for deadlines.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenters' concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter stated that there are no provisions that penalize an insurer for failing to comply with the rule.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenters' concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

N.J.A.C. 11:3-4.7B(h)1 and 2 - Acknowledgment of Appeals; Deadlines

COMMENT: Several commenters stated that the time frames for insurers to acknowledge the receipt of appeals were too short and would create an inordinate administrative burden and expense. The commenters recommended elimination of the requirement that appeals be acknowledged. One commenter suggested amending the rule

to require that late or incomplete appeals must be acknowledged within seven days for treatment appeals and 14 days for administrative appeals. Another commenter stated that if an insurer does not acknowledge an incomplete or late appeal, the insurer should not lose the ability to raise defenses in a subsequent arbitration.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenters' concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter suggested that this section be amended to permit an insurer to require in its DPR Plan that a facsimile confirmation meets the requirement to acknowledge receipt of appeals. The commenter noted that N.J.A.C. 11:3-4.7B(d)4 already states that a fax confirmation sheet shall be evidence that an appeal, acknowledgment, or decision was faxed and received. The commenter believed that its suggested change would decrease administrative time and expense. The commenter also requested the opportunity to review and comment on the acknowledgement form to be developed by the Department.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenters' concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to

adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter believes that the requirements in N.J.A.C. 11:3-4.7B(h)1 and 2 that the insurer acknowledge receipt of a treatment appeal within three business days would increase costs in light of the number of appeals expected. The commenter stated that since the insurer must respond to a treatment appeal within 10 days, requiring a process for the immediate confirmation of receipt of the appeal needlessly adds to insurer expenses. Another commenter suggested that there be one final decision notification for each submitted appeal.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenters' concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

N.J.A.C. 11:3-4.7B(h)3 - Incomplete/Late Appeals

COMMENT: One commenter requested more clarity in the rule on how to handle incomplete and late appeals. The commenter asked if providers had to remedy the deficiencies and if the insurer had to address medical necessity of late or incomplete appeals. Another commenter inquired whether a carrier can simply deny an appeal on the basis that it lacks the correct information described in N.J.A.C. 11:3-4.7B(d)2. If so, does the deadline suspend until such additional information is submitted by the provider?

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenters' concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: Several commenters stated that there should be a distinction between incomplete appeals-those that are missing the categories of information mandated by N.J.A.C. 11:3-4.7(B)(d)2 and those that contain all the information required but contain an error or incorrect information. In the latter case, the commenters urge that a provider should be allowed an opportunity to cure the error, and that the cure period should extend the time in which the provider can submit an "appeal."

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenters' concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

N.J.A.C. 11:3-4.7B(i)1 and 2

COMMENT: One commenter stated that N.J.A.C. 11:3-4.7B(i)1 and 2 should be amended to incorporate the use of the concept of "service," as described in earlier Comments, instead of the "received by the insurer" construct in the adopted but delayed

rule. The commenter also requested that the above subsections be amended to provide for the parties to agree to an extension of time in the event that the insurers request additional information and the provider agrees to provide the information. Several commenters noted that an insurer cannot guarantee receipt by a provider of a decision within the time frames listed. The commenter suggested that the time frames in the rule should run from when the insurer sent the decision plus an additional three days for mailing as provided in the New Jersey Court Rules (R. 1:3-3).

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter suggested that insurers should have 15 days to respond to treatment appeals instead of the 10 days provided in the proposed rule. Several commenters stated that this provision should be amended to require that the insurer conduct such review and notify the provider of its decision within 30 days of receipt of the appeal.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to

adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter inquired what type of notification of the appeal decision is acceptable, and requested confirmation that an EOB is sufficient notification of a decision under N.J.A.C. 11:3-4.7B(i).

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter requested that N.J.A.C. 11:3-4.7B(i)2 be clarified to provide that the time periods for issuing an appeal decision when an IME has been requested should start from when the examination has been conducted, not when the report has been received, since this may lead to undue delays because there is no required time frame for an IME report to be produced.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

N.J.A.C. 11:3-4.7B(i)3

COMMENT: One commenter sought clarification as to whether the stay of the time frames for responding to appeals where the insurer has requested an IME applies to any treatment request submitted for the provider specialty.

RESPONSE: The Department does not understand the comment. The stay of response deadlines only applies to appeals, not treatment requests made through the APTF.

COMMENT: One commenter stated that the Department did not include any deadline for the carrier to complete the IME and transmit the report and considers this too open-ended and subject to dispute. Another commenter stated that IME doctors should be more closely reviewed by the Department to ensure that patients are getting fair results in their exams by physicians who wish to maintain their favorable reputations with the insurance companies. Another commenter stated that the time period should start after the examination has been conducted and not at the time the report is received by the carrier.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenters' concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: Several commenters inquired whether, if the insured fails to cooperate with the IME request or is a no-show, does that automatically void the appeal/allow the

insurer to consider the appeal to have been withdrawn by the provider.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenters' concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter requested that the Department clarify N.J.A.C. 11:3-4.7(e), which is referenced in N.J.A.C. 11:3-4.7B(i)3, to state that the requirement that a physical examination be scheduled within seven days does not mean that the examination must be conducted within seven days.

RESPONSE: The comment is outside the scope of the proposal. N.J.S.A. 11:3-4.7(e) was not proposed for amendment. Moreover, the Department does not believe any clarification is necessary. The rule currently states that the appointment for a physical examination must be scheduled within seven days.

COMMENT: Several commenters stated that they strongly supported the proposed internal appeal process as a way of avoiding time-consuming, unnecessary, and costly litigation. The commenters stated further that, to be effective, the internal appeals process must be mandatory and must be a jurisdictional prerequisite to filing arbitrations. The commenters noted that the Summary of the proposal appears to acknowledge that fact by stating that the demand for arbitration must be accompanied by a certification that an appeal was made and no decision was received from the insurer. Several commenters

stated that this provision is not included in the rule. One commenter maintained that more specific rules governing the submission of the proof of the appeal should be promulgated, setting forth a procedure for filing proof of an appeal so that it is consistent among all dispute resolution organizations. One commenter believed that the provision in the referenced section which permits the DRP to impose penalties on providers and their attorneys who misrepresent the status of an internal appeal in their demands for arbitration is not a sufficient deterrent since the DRP may only impose nominal penalties and permit the arbitration to continue. One commenter stated that the penalties that can be imposed, such as dismissal of the case, should be identified. Another commenter requested that the subsection be amended to include the requirement of the certification mentioned above and dismissal, with prejudice, of any demand for arbitration that does not contain either an internal appeal decision or the certification described above. Several commenters suggested adding language that specifically prohibits claimants who have not exhausted the internal appeal process from filing arbitrations. These commenters also recommended that the penalty for a provider who violates the rule be the voiding of the assignment of benefits.

RESPONSE: The Department appreciates the support but it also agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenters' concerns as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter suggested that the language in N.J.A.C. 11:3-4.7B(j)1

authorizing the dispute resolution administrator to include penalties for providers and their attorneys who make arbitration requests without exhausting the internal appeals process could be interpreted to mean that it was not necessary to exhaust the internal appeal process before filing for arbitration. Another commenter suggested that the penalty for filing an arbitration demand without exhausting the internal appeals process should include dismissal of the claim with costs to the appellant. Another commenter stated that the Department does not have statutory or regulatory authority to impose penalties on providers and their attorneys who make arbitration demands without having exhausted their internal appeals process. Only the Legislature or perhaps the courts could do so. Another commenter stated that it is ridiculous for there to be penalties, because this would stop people from bringing valid cases and would encourage even more improper denials.

RESPONSE: The Department does not agree with the commenters that the Department does not have the authority to impose penalties on providers and their attorneys who make arbitration filings without having exhausted the internal appeals process. Pursuant to N.J.S.A. 39:6A-5.1.b, the Department has broad authority to establish and regulate the alternate dispute resolution process. However, as noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenters' concerns as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter stated that N.J.A.C. 11:3-4.7B(j) requires that a demand for arbitration be accompanied by the internal appeal decision or proof that the appeal was filed. The commenter suggested that the rule should require that the provider submit evidence that the internal appeal was made.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter urged the Department, in the interest of streamlining the appeals and dispute resolution processes, to set forth the standards by which a provider may submit proof that an appeal was filed in compliance with the internal appeals procedure, rather than have the dispute resolution administrator set forth the standard for such proof. Another commenter indicated that there is an inconsistency in the language relating to the proof required to demonstrate that the internal appeal was filed. N.J.A.C. 11:3-5.4(b)1 addresses proof of compliance with the internal appeal process. Proposed N.J.A.C. 11:3-4.7B(j) requires that the demand for arbitration must be accompanied by the internal appeal decision or proof that the appeal was filed. The commenter argued that only a DRP has the authority to determine if the claimant has complied with the internal appeals process, not the dispute resolution administrator. The commenter asserted that the language of N.J.A.C. 11:3-5.4(b)1 should be amended to be consistent with N.J.A.C. 11:3-4.7B(j).

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's concerns as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: Several commenters objected to the penalty in N.J.A.C. 11:3-4.7B(k) for insurers who fail to respond to an appeal as unnecessarily punitive and inequitable. Several commenters pointed out that an administrative error that led to an insurer failing to respond to an appeal could result in the finding of coverage where none exists, a finding of causation where the injury is unrelated to the automobile accident or the payment of a provider charge that is significantly above the fee schedule. The commenters asserted that this result would not be consistent with the goal of creating a just and efficient PIP reimbursement system. Another commenter noted that stripping an insurer's ability to present a defense of medical necessity at an arbitration hearing is in direct opposition to one of the fundamental policies of AICRA. Another commenter stated that the penalty for insurers was disproportionate to the missed deadline, antithetical to the reforms in general, and was an inducement to providers to obfuscate appeals. One commenter stated that the traditional remedy against a party that fails to appropriately administer an internal appeals system is to deny the party the right to argue that the claimant failed to exhaust administrative appeals as a defense in litigation. The commenter urged the Department to incorporate such a remedy instead of the one in the rule. Several commenters also suggested that if the Department rejected the above

solution, it should only bar the raising of defenses to the issue that formed the basis of the carrier's original denial and not bar additional defenses not raised on the issue in the internal appeal or other issues raised in the arbitration. The commenters believed that providers and their attorneys would try and abuse the provision in the proposal by appealing issues not even considered by the insurer in its original denial so as to preclude all defenses in arbitration. Another commenter noted that carriers would be exposed to significant abuse via those who will file "catch-all appeals" that raise any/all issues and inquired how the Department will prevent abusive appeals from barring defenses. Another commenter recommended that the Department incorporate a provision contained in N.J.A.C. 11:24-8.6, the HMO rules, where the penalty for an HMO that fails to respond to an internal appeal or meet a deadline is loss of the right to require an internal appeal - not the loss of the right to argue a defense in subsequent dispute resolution or litigation. Another commenter suggested that a more appropriate penalty would be to preclude the insurer from raising procedural defenses in the appeal but would preserve the right to raise substantive defenses. Alternatively, the commenter suggested that the penalty for an insurer that failed to respond timely to internal appeal requests be the payment to the claimant of the $225.00 arbitration filing fee, regardless of which party prevailed on the merits in the arbitration. Another commenter suggested that in lieu of the default provision the Department should impose a nominal monetary penalty, perhaps based upon a percentage of the provider's bill up to a cap amount. A commenter asserted that one missed appeal can result in tens of thousands of dollars of "penalty" medical expenses. The commenter also suggested that the Department consider an alternative to the elimination of the "failure to appeal" defense for any carrier who fails to respond.

Yet another commenter suggested that in situations where the acknowledgment and or review determination is late, the provider should be awarded treatment up until the day of the acknowledgment/determination outcome.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenters' concerns as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter maintained that the penalty in N.J.A.C. 11:3-4.7B(k) for insurers is unfair to patients and providers because it gives carriers the opportunity to present additional defenses but precludes patient and providers from defending such claims within the appeal timeframe.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter stated that, "with regard to acknowledge within the time limit of proposed N.J.A.C. 11:3-4.7B(h), the penalty under this proposed subsection (k), even with the suggested changes here, should only apply to the failure to acknowledge in

the case of an incomplete appeal." The commenter further stated that incomplete appeals are the only instance covered by proposed subsection (h) in which an insurer delay in acknowledging actually holds up the appeal process.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter recommended that the entire issue of proper penalties needed to be reviewed by the Department. The commenter suggested eliminating the penalty provisions entirely from the rule upon adoption and revisiting them in a future proposal after consultation with all parties. One alternative suggested by the commenter was that a portion of the disputed billing could be paid to the provider as a penalty.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter stated that this section must be preserved as proposed, since it is absolutely necessary to compel carriers to respond and imposes the penalty of

waiver on a carrier's dilatory conduct. This penalty is consistent with and no more onerous than the penalties on providers for failing to file DPR requests or appeals.

RESPONSE: As noted above, the Department believes that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's opinion as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter stated that the proposed language should be replaced with "Any provider who files without compliance with the Regulatory Appeals Process shall be dismissed with prejudice and without fees or costs." The Department should not leave it to Forthright to enact "rules" to impose such a penalty. The commenter also inquired whether the Department wants something less than a dismissal as the result.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

COMMENT: One commenter urged elimination of the penalty for insurers for failure to response to an internal appeal because it attempts to limit legal arguments which can and will impact the overall PIP benefits. The commenter stated that this section is a complete

contradiction of the stated intent behind AICRA and will result in the payment of medically unnecessary treatment. The commenter queried as to what happens when an insured with a $15,000 standard policy has his benefits exhausted by way of default or failure to respond to an appeal and is now precluded from receiving further treatment: does this create a possible bad faith claim against the carrier for exhausting the policy via default? More appropriately, the penalty to the carrier should be to bear the filing costs associated with the arbitration process which follows a failure to respond to an appeal, regardless of outcome. One commenter noted that the language is unclear and undoubtedly will be read to mean it just applies to insurers who fail to respond at all to appeals that are filed.

RESPONSE: As noted above, the Department agrees that the internal appeal process needs to be amended in consultation with the insurers and providers and will consider the commenter's concern as part of the process. Any such amendments would be substantial requiring additional notice and opportunity for comment. The Department intends to adopt the rule with a 365-day delayed operative date that will allow time for amendments to be drafted, proposed and commented upon, and adopted.

N.J.A.C. 11:3-4.9

COMMENT: Several commenters noted that the term "duties" should be removed from the assignment of benefits language in N.J.A.C. 11:3-4.9 so that the proposed rules are not construed as contravening existing case law and the decision in *Selective Ins. Co. of America v. Hudson East Pain Management Osteopathic Medicine and Physical Therapy*, 416 N.J. Super. 418 (2010), *aff'd on other grounds* 2012 *N.J. Lexis* 769 (2012)

("*Selective Insurance v Hudson East*"). Removal of the term "duties" would clarify that the Department does not intend to indicate that an insurer could impose unilateral duties in connection with the assignment of benefits, in contravention of the holding in *Selective Insurance v Hudson East*. One commenter noted that an expansion of discovery in arbitrations by regulatory action that is beyond the scope of N.J.S.A. 39:6A-13 is both of questionable legal defensibility and will also significantly increase the amount of attorney's fees and costs in PIP arbitrations because all of the discovery would have to be performed by both the claimant's as well as the insurer' PIP arbitration attorneys, resulting in a greatly increased attorneys' certification of services, which is contrary both to the Department's intent to reduce such costs and the long standing public policy to encourage the prompt and low cost resolution of PIP disputes through the Alternate Dispute Resolution (ADR) system.

RESPONSE: The Department does not agree with the commenter that the decision in *Selective Insurance v Hudson East* precludes the assignment of duties under the policy to a provider of service benefits. As noted by the Supreme Court on certification, the Appellate Division relied upon the legally significant distinction between an assignment, which conveys benefits or the potential to receive benefits, and a delegation, which conveys duties or obligations. *Selective Insurance v Hudson East, supra*, 416 *N.J. Super.* at 426 (citing 9 Corbin on Contracts §§ 47.1, 47.6 (John E. Murray, Jr. ed. 2007)). Based upon this distinction, the Appellate Division held that a general assignment of benefits in the PIP context and the one at issue cannot function to impose the duty to cooperate under the policy unless the assignee providers expressly assent to assume the duty or were a party to the original agreement. *Ibid.* Furthermore, during the pendency

of this adoption in July 2012, the Supreme Court issued its decision in the case, which declined to express its views on this issue. In so doing, the Court pointed to the Restatement (Second) of Contracts (1979), which recognized that "[t]he principle that an assignment of benefits does not carry with it the corresponding duties of the assignor is not universal in its application[,]" and noted that the Legislature has incorporated such assumptions of duties in other statutory assignment of benefits (see N.J.S.A. 12A:2-210(4)). *Selective Insurance v Hudson East, supra*, 2012 *N.J. Lexis* 769 (2012) at slip op. *11-12. The purpose of the amendment is to clarify this issue and to permit an insurer to require that a provider accept the duty to cooperate under a policy in an express assumption of this duty along with the benefit of receiving payment from the insurer. N.J.S.A. 39:6A-4.a authorizes the Commissioner to set forth the benefits provided under the policy and N.J.A.C. 17:33B-42 authorizes the Department to implement any procedure or practice … to prevent fraudulent practices by the insured, insurers, providers of services or equipment..." The Department notes that some unscrupulous providers have refused to respond to reasonable information requests by insurers in connection with the investigations of claims. The Department also does not believe that the assignment of duties under the policy to providers will increase arbitration costs. The Department believes that this provision will prevent a significant number of arbitrations by enabling insurers to get necessary information to investigate and pay claims. Department is aware of the concern that insurers will use this provision to harass physicians and will monitor information requests made under this provision to prevent overreaching by insurers.

COMMENT: Several commenters inquired what the words "and duties under the policy"

mean. The commenters expressed concern that the new language gives carriers broad leeway to define "duties under the policy" and "the prevention of fraud" so that they can now include de facto examinations under oath (EUO) in their assignment of benefits forms. This new language can be used to harass and deter physicians who wish to arbitrate their bills. Another commenter stated DOBI currently allows some carriers to include language in their assignment of benefits forms that is unfair to physicians. This language, for example, states that assignment of benefits are void if provider does not submit to an examination under oath "when we request" or assignment of benefits are void if the provider "does not submit to an examination under oath."

RESPONSE: The Department notes that many carries already include a requirement that providers submit to EUOs in their restrictions on the assignment of PIP benefits. The Department does not believe that this is unfair to providers. As noted above in the discussion of *Selective Insurance v Hudson East*, the principal duty of the insured under the policy that would be assumed by a provider under an assignment of benefits is the duty to cooperate with the insurer. EUOs are one of the most common duties of an insured in an investigation of a claim. As noted above in the Response to another Comment, the Department intends to monitor the implementation of this provision to prevent abuses.

COMMENT: One commenter noted that N.J.A.C. 11:3-4.9(b) requires insurers to file policy language requiring providers who are assigned benefits to make an internal appeal prior to making a request for arbitration. The commenter believed that this language leaves it to the carrier to create the prerequisite of filing an internal appeal and weakens the Department's authority to regulate the issue. The commenter recommends that the

rule be clarified to state that failure to follow the internal appeal process will result in dismissal of arbitration.

RESPONSE: The Department does not agree with the commenter. Since the Department must approve all policy language, it has the necessary authority to regulate this issue. The Department also notes that the internal appeals rules are adopted herein, but will not be made effective until the Department drafts, proposes and permits comments on, and adopts amendments to those rules.

COMMENT: One commenter noted that a problem arises regarding cases in which an insurer fails to affirmatively make any denials. In those cases, a provider hardly should be required to file additional appeals.

RESPONSE: The Department does not understand the comment. If an insurer does not respond to a DPR request, pursuant to N.J.A.C. 11:3-4.4(e)1, the provider can proceed with the treatment or testing.

N.J.A.C. 11:3-5 Personal Injury Protection Alternate Dispute Resolution

COMMENT: One commenter stated that it shared the Department's concern about the large volume of disputes that go to arbitration. The commenter supported the on-the-papers proceeding for claims less than $1,000. The commenter suggested raising the on-the-papers threshold to $2,500. The commenter also recommended including language that would permit an insurer to consolidate all pending arbitration demands from the same provider and claimant into one on-the-papers proceeding. The commenter noted that these measures would reduce the number of arbitrations and result in improved efficiency for claimants and providers. Another commenter also supported the on-the-

papers proceeding if it results in lower attorney's fees in recognition of the fact that no appearance is required.

RESPONSE: The Department thanks the commenters for their support of the general implementation of the new process but does not agree with the suggestions. The Department notes that the $1,000 threshold for on-the-papers cases was recommended by the PIP Alternate Dispute Resolution Administrator as the level that would comprise approximately 25 percent of arbitrations filed. The Department will monitor the implementation of the on-the-papers provision and may revise the threshold in the future based on actual experience. The Department notes that the rules for consolidation of arbitrations are contained in the rules of the arbitration administrator, not the Department's rules, and are thus outside the scope of this proposal.

COMMENT: Several commenters commended the Department for attempting to address some of the problems and inequities associated with the current PIP arbitration system. One commenter noted that attention and focus should be placed on provider and payor training rather than on the volume of arbitrations. The commenter urged that the Department should require the arbitration administrator to provide an analysis of the carriers experiencing arbitrations with stratification of providers and attorneys. The commenter recommended that on an annual basis, outliers should be addressed with appropriate action. The commenter is concerned that it appears as though the costs of arbitrations are being blamed on provider services costs versus carrier administrative costs and that the Department should oversee this concern.

RESPONSE: As part of its oversight of the PIP arbitration process, the Department does

monitor the arbitration practices and costs of carriers as well as providers. However, the commenters' suggestions are beyond the scope of the proposal.

COMMENT: One commenter agreed with the Department's concern that the number of arbitrations has risen dramatically over the past few years and attributed this to what has become a cottage industry for a small segment of the plaintiff's bar. These attorneys, according to the commenter, mine medical providers for their accounts receivable and file arbitrations for any amount owed, no matter how small because, under the current system, if the provider is awarded any portion of its demand in the arbitration award, even amounts as low as $20.00, the provider's attorneys' fee is paid by the insurer.

The commenter attached a list of examples where although the insurer was only obligated to pay a tiny portion of the demand, nevertheless, the provider's legal fee had to be paid by the insurer. In one of the submitted examples, the disputed amount was $15,911, $25.00 was awarded but $500.00 was paid to the provider's attorney.

The commenter suggested that the Department's proposal does not go far enough in addressing this problem. The commenter recommended that the proposal be amended to state that providers are entitled to recoup their legal costs only if they are truly a successful party by receiving at least 50 percent of their demand. One commenter believed that the Department should develop a fee schedule that is mathematically tied to the amount of the award and not permit any attorney fee award to exceed the amount awarded to the claimant. Another commenter recommended that the proposal be amended to require that an award of counsel fees may not exceed the amount of the award or the amount in dispute, whichever is lower.

Still another commenter suggested that the Department create a rebuttable presumption that any attorney fee award that exceeds the amount awarded to the claimant is unreasonable.

RESPONSE: The Department does not agree with the commenters. The Department's authority to regulate attorney fees is limited by the language of N.J.S.A. 39:6A-5.2.g and the courts' jurisprudence on the reasonableness of attorneys' fees under fee-shifting statutes. N.J.S.A. 39:6A-5.2.g provides for the awarding of attorneys' fees in arbitrations consonant with the amount of the award and in accordance with a schedule established by the New Jersey Supreme Court. To the Department's knowledge, this schedule has never been issued. The Department believes that the review of attorney fees by the DRP according to the process set forth in N.J.A.C. 11:3-5.6(e) falls within the grant of statutory authority, complies with the jurisprudence of this State, and will work to limit attorney fee abuses.

COMMENT: One commenter lamented the practice of insurance companies "investigating a case" for several months, although the care was within the care paths, and being told by claims adjusters and precertification nurses acting on behalf of insurers that "if you do not like it, file a complaint and take us to PIP arbitration." The commenter noted that out of 260 cases filed by his office since 2002, only five PIP arbitrations were lost. In the past, the office would file a complaint with the Department, but has been told of late that "the Department is not a collection agency" and that the complaints must list all the details involved in the matter.

RESPONSE: The comment is outside the scope of the proposal. The Department

provides providers with the opportunity to file a complaint about insurers that do not follow the PIP DPR process.

COMMENT: One commenter noted its general support of the new arbitration rules and acknowledged that the availability of the arbitration mechanism and its implementation is an essential tool to ensure that the appropriate treatment is available to PIP patients and that UCR fees are paid to physicians. The commenter is particularly concerned about the implementation of the allocation rule, and urges the Department to monitor the arbitration case load to ensure that "low balling" is not occurring. The commenter also recommended that the Department post representative arbitration decisions on is website, to further transparency.

RESPONSE: The Department does not understand what the commenter means by the "allocation rule" or "low balling" in the context of arbitrations. The Department notes that all arbitration decisions are available in a searchable database on the website of the PIP arbitration administrator, Forthright (http://www.nj-no-fault.com/).

COMMENT: One commenter asked the Department to consider adopting rules to permit class-action arbitrations to facilitate consistency in decision making and cut transactional costs.

RESPONSE: The Department does not agree with the commenter. The Department's rules for the conduct of PIP arbitrations do not address what claims can be combined in a Demand for Arbitration and therefore the suggestion is outside the scope of the proposal. The rules of the arbitration administrator currently permit the claims for one accident or up to four persons injured in the same accident to be filed together. The proper forum in

which to raise this issue is the Advisory Council of the Arbitration administrator.

COMMENT: Several commenters disagreed with the Department's statement that PIP ADR is too costly and frivolous. One commenter believes that the current process ensures that providers will receive the money they are due for the treatment provided and if the system is altered as proposed, providers may not receive fees due to them because of an incorrect payment by an insurer. Another commenter noted that there is no cause of action for bad faith. The sole remedy by statute is arbitration with interest, attorneys' fees and costs. The carriers have the power to eliminate arbitrations by authorizing medically necessary treatment to the injured persons and paying the bills correctly.

RESPONSE: The Department does not agree with the commenters. The Department has stated that the PIP arbitration system is the most costly and time consuming dispute resolution process for PIP disputes. Therefore, every effort to resolve disputes by other less expensive and more rapid procedures, such as an internal appeal process, should be exhausted before a demand for arbitration is made. If a provider cannot resolve a dispute through the internal appeals process, nothing in the proposal prevents such a provider from filing a demand for arbitration. The Department notes that bad faith claims are outside the scope of the proposal. The Department also does not agree with the commenter that insurers could avoid arbitrations by authorizing medically necessary treatment and paying bills correctly. It is disputes about the "correctness" of treatments and reimbursements that result in arbitrations.

N.J.A.C. 11:3-5.2

COMMENT: One commenter requested a clarification of the scope of the term, "no

further treatment at issue." The commenter questioned whether this language referred to a claimant or to a provider. Another commenter recommended that "further treatment" be replaced by "future treatment" to ensure that causation issues are not decided in an on-the-papers proceeding.

RESPONSE: The Department does not agree with the commenter. The language in the adopted amendments to N.J.A.C. 11:3-5.4(b)5 simply requires that the arbitration administrator's plan include rules for on-the-papers proceedings. The detailed provisions for how the on-the-papers process works are contained in Rule 6 of the PIP arbitration administrator, Forthright, which reads, in part:

"'On-the-papers' is defined as one in which the parties or their representatives submit documentation supporting their case to Forthright, which shall transmit it to the DRP who shall decide the case based solely upon the documentation without in person or telephonic appearances by the parties or their representatives. Cases are required to be designated as on-the-papers when (1) there is no claim for future treatment or testing, and (2) the amount claimed owing for personal injury protection coverage benefits is less than $1,000 exclusive of interest, attorney's fees and costs of arbitration after all payments received by the claimant up to the day before the filing of the *Demand for Arbitration*. (For services subject to the NJ Automobile Medical Fee Schedules, no amount claimed shall be greater than the fee on the appropriate fee schedule) . . .

Within 100 days from the initiation of a case, a respondent may remove a dispute that otherwise meets the definition of an on-the-papers case to in-person arbitration because the issues in dispute involve coverage under the policy, fraud investigations by the

respondent's Special Investigations Unit (SIU) or causality of the injuries."

COMMENT: One commenter expressed concern with the description in N.J.A.C. 11:3-5.2 of matters that can be heard on-the-papers. The commenter believed that as written, a provider could have outstanding bills of less than $1,000, still be providing treatment and there would have to be an on-the-papers proceeding for a dispute involving fraud, misrepresentation, lack of cooperation, coverage or eligibility and the decision in such a case could lead to potential estoppel arguments. The commenter suggested that insurers be able to object to on-the-papers proceedings and that the award in such cases should not have a preclusive or collateral effect with regard to other issues or treatment involved in the case.

RESPONSE: The Department does not agree with the commenter. The language in the adopted amendments to N.J.A.C. 11:3-5.4(b)5 simply requires that the arbitration administrator's plan include rules for the on-the-papers proceeding. The detailed provisions for how the on-the-papers process works are contained in Rule 6 of the PIP arbitration administrator, Forthright. As noted above in the Response to the previous Comment, the rules of the PIP arbitration administrator permit an insurer to remove a dispute that otherwise would meet the definition of an on-the-papers case to an in-person proceeding.

COMMENT: One commenter noted that the "less than $1,000" criterion is not limited in any manner. A plain reading is that the billed amount has to be less than $1,000. What happens when the billed amount is more than $1,000, but the fee schedule provides for less? What happens where the billed amount is more than $1,000, yet the insurer claims

that the patient selected a limited policy and that the benefits are almost exhausted except for a sum less than $1,000, yet it is the provider's contention that the patient did not choose a limited policy and the patient would be entitled to a higher policy limit?

RESPONSE: The Department does not agree with the commenter. The language in the adopted amendments to N.J.A.C. 11:3-5.4(b)5 simply requires that the arbitration administrator's plan include rules for on-the-papers proceeding. The detailed provisions for how the on-the-papers process works are contained in Rule 6 of the PIP arbitration administrator, Forthright. As noted above in the Response to the previous Comment, the rules of the PIP arbitration administrator permit an insurer to remove a dispute that otherwise would meet the definition of an on-the-papers case to an in-person proceeding if coverage or fraud is an issue.

COMMENT: One commenter noted that not all disputes where the amount at issue was less than $1,000 are simple. The commenter suggested adding language upon adoption to N.J.A.C. 11:3-5.4(b)5 to state that the documentation that can be provided by a party for an on-the-papers proceeding is the same as for an in-person proceeding and that the dispute resolution organization can convert an on-the-papers proceeding to an in-person proceeding if such a change is needed to decide the case.

RESPONSE: The Department does not agree with the commenter's suggestion. The language in the adopted amendments to N.J.A.C. 11:3-5.4(b)5 simply requires that the arbitration administrator's plan include rules for on-the-papers proceeding. The detailed provisions for how the on-the-papers process works are contained in Rule 6 of the PIP arbitration administrator, Forthright. As noted above in response to the previous

comment, the rules of the PIP arbitration administrator permit an insurer to remove a dispute that otherwise would meet the definition of an on-the-papers case to an in-person proceeding.

COMMENT: Several commenters stated that the "paper only" arbitration hearings represent a backward step for due process in which disputes will be handled without in-person representation, or oral testimony on issues of medical necessity or coverage. One commenter noted that as proposed, the "on the papers" proceedings would prohibit the DRP from questioning the parties concerning any issues relating to the case, such as coverage, eligibility and medical necessary. The medical necessity decision should not be made by the DRP or the insurer. Another commenter noted that any dollar threshold is also an incentive for carriers to unreasonably deny medical treatment with full knowledge that a provider will be limited to argue on papers only at the time of arbitration. This will further burden DRPs who will be writing in a vacuum. Another commenter noted that the complexity of the issues is not necessarily related to the amount in question, and the arbitrator's determination as to causation in a case on the papers might have a collateral effect in PIP disputes brought by other providers or in the patient's third party liability case. Several commenters stated that there is no statutory basis for the on the papers proceedings and that this violates due process for the insured and the medical providers, equal protection, and does not comport with traditional notions of fundamental fairness. The commenters also noted that only the carrier may opt out of the on the papers proceeding. One commenter suggested that a better approach would be one whereby either party can request a hearing on the papers and either party can demand an in person hearing. Another commenter stated that the dollar saving of not

having an oral hearing is $25.00, according to Forthright. Another commenter noted that the Department's statement that the number of arbitration demands has doubled from 2005-2010 is misleading and exaggerates the scope of the PIP arbitration system. The more important statistic is the number of cases concluded, not initiated.

RESPONSE: The Department does not agree with the commenters. N.J.S.A. 39:6A-5.1 does not require in-person hearings, but instead provides for dispute resolution of PIP disputes and gives the Commissioner the exclusive power to promulgate rules as to the conduct of the PIP dispute resolution proceedings. There is nothing in the statute that requires an in-person hearing or the taking of testimony and the vast majority of PIP arbitration proceedings are conducted now without any oral testimony from the parties. Moreover, other statutory arbitration schemes on-the-papers permit summary disposition (for example, Simplified FINRA (financial industry regulatory authority) arbitration procedure, which is available for claims up to $50,000. The Department does not believe that requiring that arbitrations for less than $1,000 be determined on-the-papers violates due process or is in any way unfair. Due process is a flexible concept and at a minimum requires an opportunity to be heard at a meaningful time and in a meaningful manner. *Doe v. Poritz*, 142 *N.J.* 1, 106 (1995). Forthright's rules as approved by the Department merely provide for on-the-papers proceedings where no future treatment is at issue and the claim is less than $1,000. However, if coverage under the policy is at issue, fraud is suspected, or causation is an issue, then the insurer can remove the matter for an in-person hearing. Thus, the only cases where the on-the-papers hearings will be mandatory are reimbursement disputes between the insurer and providers for medical services already provided where the claim is for less than $1,000. Here, the parties will be

provided notice, have an opportunity to submit initial papers including evidence and certifications, and will have an opportunity to submit reply submissions responding to each other's initial submissions, and the Department believes this satisfies any due process concerns. The Department, in consultation with the Advisory Council of the PIP Alternate Dispute Resolution Administrator, Forthright, developed the on-the-papers proceeding. The Department does not agree that all parties should be able to opt out of an on-the-papers hearing. The Department believes that attorneys representing petitioners would have a financial incentive to opt out of on-the-papers hearings because they earn additional fees for appearing at in-person hearings. This is not true of respondents. Therefore, respondents are given the opportunity to opt out of on-the-papers arbitrations where fraud or causation is an issue. The Department also does not agree that the $25.00 difference in filing fees for in-person and on-the-papers arbitrations is the only cost savings. By not having an in-person hearing, the attorney cannot include travel time and an appearance at a hearing in his or her bill. The Department also does not agree that the increase in the number of arbitrations initiated is a misleading statistic about the growth of PIP arbitrations. The comparison between the number of cases decided and settled in the first quarter of 2005 and the fourth quarter of 2010 as reported in the quarterly reports of the arbitration administrator on the Department's website show that cases awarded or denied by a DRP decision increased 183 percent and the number of cases settled increased 259 percent.

COMMENT: One commenter requested that N.J.A.C. 11:3-5.4(b)1 be amended upon adoption to include a copy of the assignment or the power of attorney upon which the provider purports to act.

RESPONSE: The Department does not agree with the commenter's suggestion. Receipt by the insurer of a copy of the assignment of benefits or power of attorney is required by N.J.S.A. 39:6A-4 in order to pay a provider directly.

N.J.A.C. 11:3-5 Personal Injury Protection Dispute Resolution

COMMENT: One commenter suggested that N.J.A.C. 11:3-5.5(a)2 specify that the failure to follow the internal appeal process mandated by N.J.A.C. 11:3-4.7B will result in the dismissal of the arbitration with no award for costs or fees. The commenter suggested the following amendments to N.J.A.C. 11:3-5.5(a)2 (additions in boldface; deletions in brackets):

"Providers who are the assignee of benefits by the insured or have a power of attorney from the insured shall follow the **regulatory** [insurer's] internal appeal process mandated by N.J.A.C. 11:3-4.7B before making a request for dispute resolution in accordance with (a) above. **Any demand for arbitration filed without a valid assignment of benefits and proof of compliance with the regulatory process shall be dismissed with prejudice and with no award for costs or fees. [**The dispute resolution organization's plan shall include a procedure for how the provider shall demonstrate that this requirement has been satisfied.]"

RESPONSE: The Department does not agree with the commenter. The detailed requirements on what must accompany demands for arbitration are best addressed in the PIP Arbitration Administrator's rules. These rules already require, for example, that an assignment of benefit accompany a demand for arbitration. Additionally, the Department notes that no amendments to N.J.A.C. 11:3-5.5(a) were proposed in this rulemaking.

COMMENT: One commenter requested the anonymous assignment of a DRP in on-the-papers proceedings be deleted from the adopted rule. The commenter believed it was a waste of time and resources to require parties to submit objections to the assignment of a DRP only after a decision is rendered. The commenter also believed that this provision would cause unsuccessful parties in on-the-papers proceedings to flood the arbitration administrator with objections to the DRP, which would waste time and resources. Another commenter stated that the parties should be made aware of the identity of the DRP prior to the submissions of the parties and the closing of the hearing so they may adequately prepare their submission and challenge the appointment of the DRP if applicable. The commenter claimed that the Department is attempting to undermine the DRPs and the courts and insert its position that the DRPs are improperly ruling on attorney fees. The Department has not cited to a single case where the court determined a DRP did not properly weigh the factors for attorney fees.

RESPONSE: The Department does not agree with the commenter. The arbitration administrator has a two-step process to prevent conflicts of interest for DRPs. The administrator has a list of entities that pose a conflict for each DRP. For example, if a DRP previously worked for an insurance company, that DRP would not be assigned cases involving that company. In the second level, the DRP reviews all the parties in each case that they are assigned to see if there any conflicts. The result is that challenges to DRP assignments are very uncommon. Where disputes are determined on the papers and there is no need to contact the DRP in advance of the decision, there is no need to notify the parties of the identity of the DRP. The Department will request that the PIP Arbitration

Administrator monitor the on-the-papers process and advise the Department if problems such as those described by the commenter occur.

COMMENT: One commenter noted that if an on-the-papers proceeding is converted to an in-person hearing, the proceedings should be assigned to the region selected by the filing party.

RESPONSE: The comment is outside the scope of the proposal. The Department notes that the assignment of regions is contained in the rules of the PIP Arbitration Administrator.

COMMENT: One commenter indicated that proof of internal appeals can be horribly burdensome.

RESPONSE: The Department does not agree with the commenter. The Department's goal is to make a simple, uniform process for providers to demonstrate that an appeal has been filed while still ensuring that arbitrations are not filed when the provider has not followed the internal appeal process.

COMMENT: One commenter noted that it appreciated the Department's attempt to provide additional guidance to DRPs in the award of attorney's fees. The commenter's preference would be for a "successful claimant" to be defined as where the claimant is awarded at least 50 percent of the demand. Another commenter commended the Department for recognizing that part of the problem with the current system is an attempt by some providers to game the system through arbitration or litigation. The commenter noted, however, that reliance on lodestar has proven ineffective in other states and the commenter encourages the Department to be more proactive to control outrageous

attorney fee awards. One commenter recommended that the Department require claimant attorneys to use the Forthright attorney fee certification form, and stated that a DRP should specify the hourly rate and number of hours awarded.

RESPONSE: The Department does not agree with the commenters. The Department does not believe that it has the authority to define "successful claimant" as suggested by the commenter. As noted above in response to other Comments, the Department will monitor how the lodestar procedure for determining attorney fees is implemented and if the Department determines that the methodology is not producing results in accordance with N.J.S.A. 39:6A-5.2.g's parameters that the fees be consonant with the award, the Department will consider other alternatives.

COMMENT: One commenter stated that the proposed regulations expand what a dispute resolution professional considers when determining reasonable attorneys' fees, thereby further incentivizing insurance carriers to deny coverage. Several commenters further declared that the proposed standard violates the New Jersey Constitution because only the New Jersey Supreme Court has the exclusive power to regulate the practice of law and establish standards for counsel fees. In addition, by placing greater limitations on fee awards, DOBI encourages insurance companies to go through the arbitration process, especially for smaller claims, since their potential losses are less under the proposed regulations. Although attorneys' fees can have a deterrent effect on insurance companies' inappropriate reimbursement practices, the proposed regulations eliminate much of that effect. Another commenter claimed that consumers will be adversely affected if the Department requires the DRP to contain costs by substantially decreasing attorneys' fees. Another commenter noted that permitting attorney fees to be

commensurate with settlements/award amounts will create an incentive for carriers to deny low dollar treatments, knowing that most medical providers will be unable to retain an attorney for representation because of the lawyer's inability to recoup litigation costs and fees.

RESPONSE: The Department does not agree with the commenters. Attorney fees are not intended to have a deterrent effect on insurers, nor does the Department believe that consumers could be harmed by a structured, rational review of the fees submitted by attorneys. N.J.S.A. 39:6A-5.2 states that, "fees shall be determined to be reasonable if they are consonant with the amount of the award, in accordance with a schedule established by the New Jersey Supreme Court." As noted above, the Court has not issued such a schedule, but that does not eliminate the statutory mandate that fees shall be consonant with the amount of the award. The Department believes that the incorporation into the rule of lodestar procedures espoused by the State's jurisprudence for use under fee-shifting statutes merely provides a framework for the DRP to apply the "consonant with the award" standard. Since there is a specific statutory provision governing the awarding of attorney fees in PIP arbitration cases, the Department does not believe that the adopted rule violates the New Jersey Constitution. This is especially true since the New Jersey Supreme Court has not established a fee schedule pursuant to the statute. Finally, the Department believes that the commenter's suggestion that the adopted amendments will provide any incentives to insurers to deny claims is speculative and notes that the Department is not "permit" attorney fees to be commensurate with settlement/award amounts, but rather is implementing the requirement imposed by N.J.S.A. 39:6A-5.2.g that attorney fees shall be consonant with the amount of the award.

COMMENT: Several commenters suggested that N.J.A.C. 11:3-5.6(e) be amended upon adoption to be consistent with existing case law, specifically *Hensley v. Eckerhart*, 461 *U.S.* 424 (1983) which was accepted by the New Jersey Supreme Court in *Rendine v. Pantzer*, 141 *N.J.* 292 (1995). One commenter suggested the following change to N.J.A.C. 11:3-5.6(e)1iii to make it consistent with *Hensley* and *Rendine* (additions in boldface; deletions in brackets):

"The lodestar total calculation [may] **must** also be reduced if the claimant has only achieved partial or limited success and the DRP determines that the lodestar total calculation is therefore an excessive amount. [If the same evidence adduced to support a successful claim was also offered on an unsuccessful claim, the DRP should consider whether it is nevertheless reasonable to award legal fees for the time expended on the unsuccessful claim.] **Where the claimant has failed to prevail on a claim that is distinct in all respects from the successful claims, the hours spent on the unsuccessful claims must be excluded in determining the amount of a reasonable fee. Where the claims are related, but claimant has achieved only limited success, the DRP must award only that amount of fees that is reasonable in relation to the results obtained.**"

Another commenter recommended that N.J.A.C. 11:3-5.6(e)1iii be amended upon adoption to read:

"Attorney fees may be awarded only to 'successful claimants' - meaning that the claimant is awarded at minimum 50 percent of the amount in dispute and that the fees be capped at the lesser of the amount awarded and the amount in dispute. In addition, the

DRP shall reduce the fee award if the claimant achieved limited success in relation to the relief sought. Furthermore, a claimant's attorney is not entitled to receive fees for services on unsuccessful claims that are unrelated to successful claims."

Several commenters stated that the proposal seems to suggest that it is up to the DRP to decide if attorney fees should be reduced where there is limited or partial success. One commenter suggested the following language (additions in boldface; deletions in brackets):

"The lodestar total calculation [may] **shall** also be reduced if the claimant has only achieved partial or limited success and the DRP determines that the lodestar total calculation is therefore an excessive amount. [If the same evidence adduced to support a successful claim was also offered on an unsuccessful claim, the DRP should consider whether it is nevertheless reasonable to award legal fees for the time expended on the unsuccessful claim.] **The DRP shall award no fees or costs for an unsuccessful claim.**"

RESPONSE: The Department does not agree with the commenters. The Department believes that the attorney fee analysis comports with the "consonant with the award" requirements in N.J.S.A. 39:6A-5.2(g) and the New Jersey Supreme Court's decision in *Rendine,* and the other jurisprudence as noted in the Summary to the notice of proposal. See also *Szczepanski v. Newcomb Medical Center, Inc.*, 141 *N.J.* 346 (1995); *Furst v. Einstein Moomjy, Inc., et al.*, 182 *N.J.* 1 (2004); *Allstate Ins. Co. v. Sabato*, 380 *N.J. Super.* 463, 472-474 (App. Div. 2005); and *Scullion v. State Farm Ins. Co.*, 345 *N.J. Super.* 431 (App. Div. 2001). Additionally, as noted above, the Department does not

believe that the statutory authority in N.J.S.A. 39:6A-5.1 and 5.2 provide authority to define "successful claimants" as only those claimants that are awarded a minimum 50 percent of the amount in dispute.

COMMENT: One commenter believed that the Department can and should go farther in limiting the award of attorney's fees in PIP arbitrations than what was proposed. The commenter suggested that the Department adopt language similar to that in New York State, which allows a minimum attorney fee of $60.00 and a maximum of $850.00, capped at 20 percent of the claimant's award. The commenter believed that this pragmatic control of attorney's fees will minimize the financial incentive behind filing non-meritorious, costly arbitrations, thus reducing the total number of arbitrations.

RESPONSE: The Department does not agree with the commenter. New York's arbitration attorney fee structure is established by statute. As noted above in the Response to another Comment, the Department does not have the statutory authority to adopt such a rule.

COMMENT: One commenter stated that when awarded attorney's fees were higher than the PIP award, this may be because the Department failed to consider that the DRP may have taken into account other factors such as: the complexity of the issues; whether the issues were legal or novel arguments; the insurer's justification for litigating; and the totality of the circumstances. Another commenter noted that as more and more regulations are enacted, providers have no choice but to have an attorney handle the claims. Another commenter noted that according to Forthright's quarterly report to the Department for the second quarter 2011, out of 3,990 cases that were not settled or

withdrawn, only 24 were dismissed and only 807 were denied, meaning that in 79.17 percent of the claims, insurers were found to have denied payment for valid claims.

RESPONSE: The Department does not agree with the commenter. DRP decisions with awards of attorney fees typically contain a statement simply stating that the fee submitted by the petitioner's attorney is reasonable. Under the adopted new rules, the DRP can award an attorney's fee that is higher than the award but he or she must delineate what special circumstances make such an attorney's fee reasonable. The Department disagrees with the commenter's analysis of the arbitration statistics. The 79.1 percent of "successful" claims described by the commenter do not all involve denial of payments for valid claims. In many cases, the dispute is about what the correct payment is for a treatment that was approved. A "successful" claim also includes disputes about the medical necessity of treatments where only one of several treatments is found to be necessary.

COMMENT: One commenter opposes the proposed rules regarding counsel fees because the No-Fault Act does not authorize the Department to incorporate the jurisprudence of the state for other fee-shifting statutes into the No-Fault Act and the Department has misconstrued the jurisprudence of the State. The lodestar analysis proposed by the Department fails to include an upward adjustment or enhancement of the lodestar due to the non-contingent nature of the counsel fee. In addition, the Department ignores an essential holding in *Szczepanski* that fee-shifting statutes do not require proportionality between damages and counsel fees.

RESPONSE: The Department disagrees with the commenter. As noted above in the

Response to another Comment, the Department believes that the attorneys' fee analysis in the rule comports with the statutory authority of N.J.S.A. 39:6A-5.2.g and the jurisprudence for awarding fees under a fee-shifting statute. Moreover, the Department does not ignore the holding in *Szczepanski*. Although proportionality analyses are not required under fee-shifting statutes, the fee shifting statute here, namely N.J.S.A. 39:6A-5.2.g, specifically provides for a type of proportionality analysis by expressly stating that "fees shall be determined to be reasonable if they are consonant with the amount of the award." N.J.A.C. 11:3-5.6(e)2 merely incorporates this statutorily required proportionality analysis based upon the jurisprudence of this State.

COMMENT: One commenter suggested that the lodestar analysis required by N.J.A.C. 11:3-5.6(e)1 also include the existence and complexity of legal issues involved in the case. The commenter noted that most arbitrations arise out of medical necessity arguments where the legal analysis is limited and the law settled. The commenter also recommended that the attorney fee award be consonant with the legal complexity of and novelty of the matter at issue. Another commenter sought clarification about how the term "grossly disproportionate" will be applied. The commenter noted that reasonable people can differ about what constitutes a "grossly disproportionate" fee. The commenter recommended that the Department either develop its own schedule for attorney's fees that is tied to the amount of the award or create a rebuttable presumption of unreasonableness for any attorney's fee that exceeds the amount of the award. The commenter stated its belief that attorneys' fees are a major factor in driving up insurer and vendor PIP costs.

RESPONSE: The Department does not agree with the commenter that the lodestar

analysis should include the legal complexity or novelty of the matter. The Department is incorporating into the regulation the process for determining the reasonableness of attorney fee awards under fee-shifting statutes as established by the jurisprudence of this State. As that jurisprudence does not include legal complexity or novelty as a factor in determining the reasonableness of attorney fee awards, the Department does not believe that it should be incorporated into its process. If experience with implementing the process suggests that such standards should be added, the Department will do so in future rulemaking. As for the definition of "grossly disproportionate," the Department notes that the standard came from the New Jersey Supreme Court decisions upon which the lodestar analysis is based and suggests that those and subsequent cases might provide guidance on that issue. Ultimately, it will be the DRP's analysis that will determine if the standard is met. As noted above in the Response to another Comment, the Department does not have the statutory authority create its own schedule for attorney fee awards.

COMMENT: One commenter suggested that there be a presumption in the analysis required by N.J.A.C. 11:3-5.6(e)2 that the fee award be less than the amount awarded unless there are new, novel or complex legal arguments that would justify the lodestar calculation.

RESPONSE: The Department disagrees with the commenter. The paragraph merely requires analysis of whether attorneys' fees that exceed the amount of the award are consonant with the amount of the award. Consonant does not mean equal or less than, but requires analysis of whether the fee is compatible and/or consistent with amount of the award. The Department also notes that the addition of new items to be analyzed by the DRP in the award of attorney fees would be a substantial change upon adoption

requiring additional notice and comment.

COMMENT: One commenter inquired what the terms “grossly disproportionate” and “heightened review” mean?

RESPONSE: Concerning the definitions of “grossly disproportionate” and “heightened review,” the Department notes that the standards came from the New Jersey Supreme Court decisions upon which the lodestar analysis is based and suggests that those and subsequent cases might provide guidance on that issue. Ultimately, it will be the DRP’s analysis that will determine if the standard is met. As with many things in a PIP arbitration, including determination of what the appropriate reimbursement amount may be or the causation of a particular injury, DRPs are properly entrusted with authority to analyze imprecise and often complex legal and financial arguments, and the Department believes that this attorney fee analysis is no different.

COMMENT: One commenter welcomed the provision requiring arbitration awards to be made to the provider who is the assignee of benefits, but stated that the time period for making payment should be reduced from 45 days to 30 days so as not to unnecessarily financially disadvantage small physician practices and possibly result in delays to patient care.

RESPONSE: The Department does not agree with the commenter. Once a decision by the DRP has been issued, the parties have 35 days to request a modification or clarification or to appeal the decision to a three-DRP panel. Payments to a petitioner cannot be made until it is clear that these deadlines have run.

COMMENT: One commenter noted that the date for calculating time will change to an

insurer's receipt of a copy of the award, rather than when the award is forwarded by Forthright, which becomes a question of fact. Several commenters also noted that the insurers do not pay the attorney's fees through the provider, but directly to them. One commenter stated that not all payments should automatically go to the provider, even if there is an assignment of benefits: there may be liens that must be reimbursed or money that must be held in escrow pending resolution of the patient's liability case. The apportionment of all payments should be determined by the DRP, not imposed by rule.

RESPONSE: The Department does not agree with the commenter. The existing rule reads, "If the award requires payment by the insurer for a treatment or test, payment shall be made, together with any accrued interest pursuant to N.J.S.A. 39:6A-5, within 20 days of receipt of a copy of the determination." The proposed amendment made no change to receipt of the award being the trigger for payment except to clarify that it refers to receipt by the insurer and to change the number of days for payment. The Department does not disagree with the commenter's observations that currently insurers may pay attorney fees separately to the attorney. However, upon the adoption of the rule, the Department is requiring that the payment be made to the provider. It will be up to the provider and his or her attorney to put money in escrow or pay the attorney.

COMMENT: One commenter supported the one-year bar preventing a DRP from appearing before other DRPs following service as a DRP.

RESPONSE: The Department appreciates the support. However, as noted above in response to Comments to the original proposal, the Department believes that the current conflict of interest rules and RPC 1.12 governing attorneys prohibit the conduct that was

at the heart of the Department's proposed new rule. Therefore, the Department determined that the new regulation in N.J.A.C. 11:3-5.12(f) is unnecessary and, as was proposed in the notice of proposed substantial changes, the provision is being deleted from the proposal upon adoption.

N.J.A.C. 11:3-29 Medical Fee Schedules: Automobile Insurance Personal Injury Protection and Motor Bus Medical Expense Insurance Coverage

COMMENT: One commenter stated that the proposal does not address the substantial inequity of requiring insurers, their policyholders, and claimants to pay a substantial premium for medical services above what health insurers and the Federal government pay for the same services. The commenter notes that the Medicare fee schedules are the primary base upon which medical costs are evaluated both by payors and providers. The existing fee schedule requires insurers to pay approximately 190 to 200 percent of Medicare for non-surgical services and 340 to 360 percent of Medicare for surgical services. In contrast, the commenter states that most private health insurers pay 120 to125 percent of Medicare for non-surgical services and 135 to140 percent of Medicare for surgeries pursuant to a study submitted with the comment. The commenters noted that the proposed rule actually increases these fee levels. The commenter asserts that the Department is not complying with N.J.S.A. 39:6A-4.6, which requires that the Department base the medical fee schedules on what providers receive from all payors in the market. Specifically, the commenter does not agree with the Department's determination to base fees on what auto insurers are currently paying for services. The commenter believes that this practice as exemplified by the physician fees in the current proposal and especially the OSF fees perpetuates the existing cost shift from health

payors and the Federal government to auto insurers, which increases PIP costs and accelerates the exhaustion of benefits of insureds. The commenter urged the Department to establish a voluntary managed choice program in exchange for a reduction in premium and an expansion of the buying power of the PIP coverage.

RESPONSE: The Department does not agree with the commenter. The Department believes that its fee setting process, which was developed for the 2007 amendments to the fee schedule rule and upheld by the Appellate Division in *In re Adoption of N.J.A.C. 11:3-29*, complies with the N.J.S.A. 39:6A-4.6. The fees paid by auto insurers to providers are one component of the information used to set the fees. The establishment of what the commenter refers to as a "voluntary managed choice program" is beyond the scope of the proposal.

COMMENT: One commenter applauded the Department for using the FAIR Health database, the most transparent and independent among the national data bases, as a sanity check on the newly listed fees. The commenter was heartened that the same database is one of the national databases on which carriers may rely to calculate UCR fee. The commenter urged the Department to go one step further to require carriers to use the database as one of their sources for UCR fees and to increase the disclosure requirement so insurers are required to indicate the specific fee amount associated with whichever data bases they use and the methodology used. This will increase transparency and avoid unnecessary arbitrations. The commenter also noted that databases limited to discounted fee schedules do not approximate UCR fees since no out-of-network fees are included.

RESPONSE: The Department appreciates the support but does not agree with the

commenter that the FAIR Health database should be mandated as a source of UCR fees. The Department has never mandated any national database that insurers must use in calculating UCR fees and only listed the ones in the rules as examples. There are multiple sources for this data and Department prefers to give insurers choices in how to calculate UCR fees. The Department believes that the proposed amendments to N.J.A.C. 11:3-29.4(e)1 already provide for the disclosure of UCR database information to providers.

COMMENT: One commenter noted that while the Appellate Division has sanctioned the use of paid versus billed fees to determine 75 percent of the prevailing fees for the schedule, the commenter expressed continuing concerns about whether the national databases accurately capture the actual total fees paid. The concern is that the patient portion of fees paid to out-of-network providers may not be adequately represented both in the prevailing fee for codes and the UCR. The commenter urged the Department to continue its vigilant efforts to ensure accuracy and exercise due diligence of these fee data bases.

RESPONSE: The Department thanks the commenter for the concern, but believes that its fee sources are reliable and adequate as affirmed by the Appellate Division in *In re Adoption of 11:3-29.* Nevertheless, the Department invites the commenter to provide any more specific information on this issue that they have.

COMMENT: One commenter commended the Department for its efforts to implement a more comprehensive fee schedule but believed that the reimbursement levels set forth in the schedule are extremely generous when compared to what health insurers and the government pay for such services. The commenter also stated its belief that if rising

medical costs continue unabated, policyholders will see sustained erosion in the value of their PIP benefits.

RESPONSE: The Department thanks the commenter for the support and notes that the inclusion of the additional CPT codes on the schedule is one of the many efforts in this adoption to contain PIP costs and prevent such an erosion of benefits.

COMMENT: One commenter noted that the overhaul and expansion of the medical fee schedules is a key part of the proposed rule. The commenter applauded the Department for tackling this difficult issue and urged the Department to pursue these changes in light of strong and self-interested provider opposition.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter stated that the Department should specify exactly what UCR percentile should be applied by a carrier or whether no such reduction is applicable at all. Failure to do so will simply lead to more UCR arbitrations.

RESPONSE: The Department does not agree with the commenter. The Department believes that the rule provides the necessary and appropriate tools for insurers to calculate the UCR fee for a service.

COMMENT: One commenter urged the Department to provide the industry with guidance on an acceptable source for Pharmacy UCR data. Reference to a Pharmacy UCR data source in the rules or by bulletin would avoid future disputes on this issue.

RESPONSE: The comment is outside the scope of the proposal. The Department notes that the rule already permits insurers to use national databases of fees, which would

include Pharmacy.

COMMENT: One commenter urged the Department to be aware that health care costs, especially provider charges, are a very significant driver of the explosion in PIP related costs in New Jersey. The commenter stated that it was important for the Department to produce a medical fee schedule that maximizes benefits for the injured person and avoids revenue maximization for the provider.

RESPONSE: The Department thanks the commenter for the advice.

COMMENT: One commenter expressed support of the Department's efforts to reduce costs by reducing fraud and abuse but cautioned that drastically cutting the most commonly performed pain management procedure codes under the guise of reducing fraud and abuse is unreasonable, will be unsuccessful, and is damaging for patient care. Several commenters noted that the fees for pain management procedures have been drastically reduced, from both a facility and professional perspective, without explanation or citation to sound methodology. One commenter noted that the proposal appears to have targeted specialties based on insurer complaints.

RESPONSE: The Department does not agree with the commenters that the fees for pain management procedures have been cut arbitrarily by the Department. As noted in the Summary to the original proposal and in response to other Comments, the Department uses the Resource Based Relative Value System (RBRVS) developed for Medicare to set the amounts on the Physicians' Fee Schedule. The RBRVS calculates the relative value of procedures by taking into account the physician's work required, the practice expenses for the procedure, and the malpractice premium associated with each CPT code, and it is

the only transparent, comprehensive, resource-based source of medical fee information. Periodically, Medicare adjusts the components of the RBRVS for certain codes based on updated information on practice expenses and changes in technology. In 2008, these changes resulted in the reduction of the Medicare fees for many of the codes in the 60000 series that are used in pain management. The Medicare fees for these services have been rising since then but are not at the level of the 2007 Medicare Physician Fee Schedule, which was the basis for the existing PIP fee schedule. Therefore, the reduction in the fees for these services on the proposed PIP fee schedule, which is based on the 2011 Medicare Physician Fee Schedule that incorporates updated practice expenses and technology.

COMMENT: One commenter strongly supported N.J.A.C. 11:3-29.4(g) and (g)1, which mandate that reimbursement to providers is subject to the National Correct Coding Initiative (NCCI) edits and the AMA's CPT guidebooks. The commenter stated that these provisions will end disputes about the authority of these publications.

RESPONSE: The Department appreciates the support.

COMMENT: Several commenters stated that the application of NCCI edits to procedures performed pursuant to the PIP Fee Schedule will result in further reductions in payment and there would be zero reimbursement in some categories of procedures performed in ASCs. Several commenters opined that the NCCI is not applicable in non-Medicare situations. Several commenters also noted that the structures Medicare has put in place have limitations for chiropractic. The current Medicare NCCI edits only allow for chiropractic manipulations and will not cover any other modalities administered to the patient on the same day.

RESPONSE: The Department does not agree with the commenters. Since its inception, the Department has prohibited unbundling of codes to increase reimbursement for procedures on the Physicians' Fee Schedule. The NCCI is simply a more sophisticated version of that prohibition. It is correct that application of the NCCI will result in zero reimbursement for some codes but that is because they are bundled into other codes for a specific procedure. Moreover, the NCCI is used by many private health payors. The commenter is incorrect in stating that the NCCI edits prohibit any other modalities being administered to a patient who receives chiropractic manipulation. Medicare prohibits reimbursement for services other than manipulation but the NCCI edits were amended to permit such services specifically because they are used by payors other than Medicare.

COMMENT: Several commenters noted that the imposition of the NCCI on the services covered by the PIP Fee Schedule will result in severe inconvenience to the injured patient since certain procedures cannot be performed on the same day.

RESPONSE: The Department does not agree with the commenters. The NCCI edits prevent billing for services that should not be provided together because they are duplicative and provide no benefit to the patient.

COMMENT: One commenter did an analysis of the new fees and found that most were based on a percentage of Medicare and not the FAIR fee schedule, and that the most common interventional pain management procedures - cervical Transforaminal ESI; lumbar Transforaminal ESI, epidural lysis of adhesions; cervical facet injections, lumbar facet injections, lumbar interlaminar ESI and cervical radiofrequency - were targeted for drastic reductions.

RESPONSE: The Department does not agree with the commenter. As noted above in response to other Comments, in 2007, the Department calculated the fees on the physician's fee schedule as a percentage of Medicare based on paid fee information from insurers. In 2008, Medicare reduced the fees for the procedures mentioned by the commenter based on its periodic review of practice costs. The commenter appears to be referring to the publicly available FAIR Health Consumer Cost Lookup ((http://www.fairhealthconsumer.org/), which is a database of billed, not paid, fees. The Department compared the fee schedule with the 75 percentile of the FAIR Health allowed fee module, which it purchased, and the fees for these services on the fee schedule exceeded those on the FAIR Health allowed fee database.

COMMENT: One commenter noted that billing for fluoroscopy will not be permitted, and that some procedures performed by pain management specialists and spine surgeons, such as discography, discectomy, laminotomy, laminectomy, anuloplasty, and sacroiliac joint injection, do not have complementary codes for ASC billing, and therefore many of these procedures that were performed in ASCs for many years will no longer be permitted. Patients will be inconvenienced, and in most cases, the total cost will be higher in a hospital than an ASC.

RESPONSE: The Department is following recent changes in CPT codes by the American Medical Association, which bundle fluoroscopy into certain procedures. As noted below in the Response to another Comment, the Department is following the Medicare determination of what procedures can be performed in an ASC which is based on patient safety concerns, not convenience.

COMMENTS: One commenter stated that although DOBI must set the fee schedule at the 75th percentile of reasonable and prevailing fees based on data it collects evidencing practitioners' market-based fees, it has failed to adhere to this statutory mandate and has instead continued to rely on Medicare rates for physician and ASC fee schedules and its reliance on imperfect data such as the use of Ingenix, Medicare, and workers compensation fees and irrelevant data, that is, applying a 300 percent multiplier of Medicare rate for OSF/ASC fee schedules. The fees established therefore are ultra vires and void. The commenter went on to state that the Appellate Division decision in *In re Adoption of N.J.A.C. 11:3-29,* did not absolve DOBI of its duty to collect market-based data as part of its methodology for determining fee schedules. DOBI has failed to show that the Medicare multiplier is an accurate reflection of the 75th percentile. The commenter also stated that the physician's fee schedule is subject to an as-applied challenge and that new data is available to challenge certain fees as representative of the 75th percentile.

RESPONSE: The Department does not agree with the commenter. In setting the fee schedules, the Department has followed the procedure upheld by the Appellate Division and has reviewed the available data on paid fees. This data includes Medicare, the largest health payor in the United States, which uses a resource-based relative value system of setting fees developed and maintained by physicians, FAIR Health allowed fees, fees paid by auto insurers, and the New York Workers Compensation fee schedule, which is also a resource-based value scale. The Department is not aware of any other sources of paid fee data. As with the codes that were added to the fee schedule in the rule amendments proposed in 2006, the Department has calculated the initial amounts of the

fees as a percentage of Medicare. As with the existing fees on the schedule, the Department used 130 percent of Medicare as a starting point and compared those fees to the percentages of Medicare set for other fees on the schedule. For example, if a group of surgical codes were already on the fee schedule at 300 percent of Medicare and five new codes for the same type of surgery were added, the new fees were set at 300 percent of Medicare. The Department also looked at the New York Workers Compensation Fee Schedule and the amounts paid for these services by auto insurers to further confirm that the fees meet the reasonable and prevailing fees. Finally, the Department purchased the FAIR Health Allowed Fee module for the Northern region of New Jersey and compared all the fees on the new Exhibit 1 to the 75th percentile of fees on this module. More than 85 percent of the fees on Exhibit 1 are higher than the fees in the FAIR Health data. The Department believes this methodology is consistent with the statute. As noted in the last appeal of the fee schedules, the fees on the PIP fee schedules are set at levels that are higher, and in most cases, significantly higher than the fees paid to providers by health payors. Since PIP only comprises a small percentage of health payors, setting the fees at these higher levels ensures that the fees on the schedule meet, and likely exceed in many instances, the reasonable and prevailing fees of all health payors at the 75th percentile.

COMMENT: Several commenters stated that lowering fees paid in a system that is "Byzantine" will discourage physicians and surgeons from caring for PIP patients. A more nuanced approach would take into account the needs of the patients and the physicians and surgeons who care for them, and the costs. The Department has a responsibility to encourage physicians and surgeons to participate in the PIP program.

RESPONSE: The Department does not agree with the commenters. The fees on the PIP

fee schedules are set at levels that are higher, and in most cases, significantly higher than the fees paid to providers by health payors. The Department has a responsibility to preserve the value of the PIP policy benefit to insureds, to make sure that insureds get the most treatment for their claim dollar.

COMMENT: One commenter stated that code 0232T has been added to the OSF fee schedule. In the past the reimbursement for this treatment was $2,000; the fee and coverage was removed from the Highmark Medicare fee schedule, setting the OSF reimbursement at $86.36. The kits to administer Platelet Rich Plasma (PRP) range in price from $110.00 to $300.00 depending on the size of the area being treated. Based on the Medicare reimbursement, physicians will not be able to employ this successful treatment because of the revenue loss. In addition, there seems to be large, unjustified differences in the reimbursements for northern versus southern New Jersey.

RESPONSE: The Department does not agree with commenter. In 2010, the AMA established a new technology code for PRP injections, 0232T. Pursuant to the procedure upheld by the Appellate Division, the Department has set this fee at 130 percent of the fee for this procedure established by Medicare. The Department notes that N.J.A.C. 11:3-29.4(g)5 limits the use of PRP to the treatment of chronically injured tendons.

COMMENT: Several commenters supported the Department's expansion of the Ambulatory Surgical Facility fee schedule to surgeries performed in hospital outpatient departments. The commenters also urged the Department to establish a hospital fee schedule to further control PIP costs. Another commenter stated that it expected that with the adoption of the Outpatient Facility Fee Schedule, there would be cost shifting

from outpatient to inpatient hospitals and urged the Department to adopt a Hospital Inpatient Fee Schedule.

RESPONSE: The Department appreciates the support but notes that it does not intend to propose a hospital fee schedule at this time.

COMMENT: One commenter stated that since ASC facilities are no longer a relatively new phenomenon, as they were in 2007, there is readily available data to determine the 75th percentile of reasonable and prevailing market based fees. While the Appellate Division accepted the 300 percent of Medicare rate because there was a lack of accessible data, this is no longer the case. The commenter provided a chart that indicates a substantial disparity between the OSF fee schedule and the average amount paid for certain services. The commenter concluded that the proposed ASC fee schedule is therefore ultra vires.

RESPONSE: The Department does not agree with the commenter. The Department is not aware of any available source of paid, not billed, facility fees for ASCs or hospital outpatient facilities other than Medicare. The Department notes that the commenter has not identified any such source of data, the chart provided does not provide its data support or source, and is therefore inadequate to demonstrate that the Department's use of Medicare as affirmed by the Appellate Division is ultra vires. Therefore, the Department is continuing to set the ASC facility fees at 300 percent of Medicare.

COMMENT: One commenter urged the Department to exempt all hospital claims from the proposed fee schedules. The commenters noted that hospitals are typically paid a different rate for similar cases depending on a preset or negotiated rate with each

patient's payors. For example, Medicare and Medicaid fee for service patients are typically reimbursed at the lowest rates, which average below the costs of providing care, pursuant to State and Federal government fee schedules; hospitals negotiate rates with their largest payors under managed care contracts, in which the rates negotiated are well below average fees in exchange for high volumes of business into clinical programs. Plans with fewer covered persons typically pay higher rates because they provide less patient volume. Patients that receive care at a hospital that is not covered under a fee schedule or managed care contract are billed according to a hospital charge master and then granted a discount negotiated with the payor. Uninsured and self-pay patients either receive charity care or a discounted rate according to State law and individual hospitals' compassionate care policies. PIP carriers currently receive the best private payor rates, regardless of the volume of cases they provide. Thus, it is unclear why PIP carriers require a hospital outpatient fee schedule to obtain access to generous hospital outpatient rates provided to the hospitals.

RESPONSE: The Department does not agree with the commenter that it is appropriate to delete all hospital claims from the proposed fee schedules. As noted above in the Response to another Comment, the Department recognizes that ASCs and outpatient hospital facility fees should not be reimbursed at the same level. The Department notes that the commenter has not provided any documentation on its analysis of how hospitals are reimbursed.

N.J.A.C. 11:3-29.1

COMMENT: One commenter stated that the language of N.J.A.C. 11:3-29.1(a) is

confusing and inquired whether the Department is suggesting that if the UCR is less than the fee schedule, a carrier is permitted to pay the lesser UCR amount. Another commenter noted that the newly proposed rule is confusing and mixes the statutory standard for the prevailing fee with the determination of UCR. The commenter assumes that this is a drafting error, since the insurer's limit of liability is either the fee in the schedule for a specific code or the UCR calculated fee for codes not listed. There is no circumstance in which a fee for a listed code is compared to an unlisted UCR determined fee. To the extent that the Department is trying to address a situation where a physician's fee is less than that on the schedule, the courts have found that the insurer's liability is only to pay the physician's stated fee. The "whichever is less" language in the proposal is confusing and the commenter urged that it be deleted. One commenter urged the addition of the following language at the end of the provision "or the contracted rate with an ODS or WCMCO network" since the contracted rate that a provider has with one of these entities can be lower than the fee schedule.

RESPONSE: The Department does not agree with the commenters. The proposed new language in N.J.A.C. 11:3-29.1(a) is merely a relocation, albeit in a slightly different form, from the existing language in N.J.A.C. 11:3-29.4(a) regarding the proper amount of reimbursement. The purpose of the relocation to N.J.A.C. 11:3--29.1(a) is to make it clear that this is the scope of the whole subchapter. Ever since the rule was originally proposed in 1990, the fee schedule rule has contained language stating that the fees on the schedules are the ceiling and that if the provider's UCR fee is less than what is on the fee schedule, then the lesser amount is what the insurer should pay.

COMMENT: One commenter noted that N.J.A.C. 11:3-29.1(d)4 states that, "Non-

emergency outpatient services on the fee schedule, including those provided by the above facilities, are subject to this subchapter." The commenter asked if it was the Department's intention that non-emergency outpatient services for both physicians and outpatient facilities that are not on the fee schedule be subject to the usual, customary, and reasonable fee. Another commenter asked if the Department envisioned that the PIP fee schedule will be the maximum liability owed for any covered service irrespective of any in-force contract that may be in effect between a PIP vendor, including a WCMCO and a hospital. The commenter suggested that the Department add language to N.J.A.C. 11:3-29.1(d)4 to clarify its intent with regard to these existing contracts. The commenter believes that such a clarification is necessary to avoid future discrepancies and to provide clarity for hospitals and PIP vendors. Another commenter sought clarification whether the fee schedule applies to the actual emergency room (ER) visits, which typically include MRI, x-ray, etc. Under the former rules, the fee schedule was applied to ER visits if the CPT code was in the fee schedule.

RESPONSE: The Department notes that N.J.A.C. 11:3-29.1(d)4 was amended in the notice of substantial change to delete the sentence quoted by the first commenter. N.J.A.C. 11:3-29.4(a)4 was added to clarify that the fees in the fee schedules apply regardless of the place of service except as specifically noted in N.J.A.C. 11:3-29.4(d)1 through 3. For fees that are not on any fee schedule, N.J.A.C. 11:3-29.1(a) was amended to state that the insurer's limit of liability is the usual, reasonable and customary fee. The Department does not believe that any additional clarification is necessary. As was noted above in the Response to another Comment, the amounts on the fee schedule are the ceiling. If the provider's UCR, including fees agreed to in contracts between auto

insurers and HMO's and PPO's that have contracted with providers, are less than the amounts on the fee schedule, that is the what the insurer should pay. The proposed amendments and new rules do not change the -ER designation in N.J.A.C. 11:3-29.4(a)3, which is applied only to surgery performed in emergency rooms.

N.J.A.C. 11:3-29.2

COMMENT: One commenter stated that defining hospital outpatient by the number of hours admitted to the hospital creates an incentive for hospitals to admit patients for greater than 24 hours unnecessarily in order to circumvent the fee schedule. The commenter recommended deleting the definition of "hospital outpatient" believing that the other definitions in the rule are sufficient to exempt trauma care and critical care from the fee schedule. Another commenter suggested that, as proposed, the "24 hour standard" in N.J.A.C. 11:3-29.2 will be abused by hospitals who will simply admit surgical patients for a nominal time beyond that threshold. One commenter suggested that the fee schedule be applied per service rather than indicating a time frame.

RESPONSE: The Department believes_that the commenters have misinterpreted the definition of "outpatient" in the rule. The rule does not define outpatient by the number of hours that a patient stays in the hospital. The Department notes that the fee schedule is applied by service, not by time, but the same services can be performed on an inpatient or outpatient basis. Therefore, it does not agree with the commenter's suggestion.

COMMENT: One commenter sought clarification of "known diagnosis" in the hospital outpatient definition and suggested changing the reference to non acute elective procedure, scheduled procedure versus non-scheduled procedure.

RESPONSE: The Department does not agree with the commenter. The commenter has not explained why the term “known diagnosis” used in the Medicare definition of “outpatient” needs clarification. The Department will monitor the use of the definition and, if changes are necessary, will make them in future rulemaking.

COMMENT: One commenter noted that there is an increase in the number of patients held in “observation status” by a hospital, as a holding pattern for patients whose doctors are not sure whether to send home or to admit. The commenter asked whether treatment given to patients in “observation status” is considered to be “hospital outpatient.”

RESPONSE: The Department believes that a patient is an outpatient until he or she is admitted and, therefore, any treatment given to patients in “observation status” would be considered to be outpatient.

COMMENT: One commenter asked if the -TS modifier is required on every CPT/Rev code billed or only on the ER visit code in order to flag the bill as a trauma case?

RESPONSE: The -TS modifier should be attached to every procedure (CPT/HCPCS) code that is performed when the trauma unit in a Level I or Level II trauma center is activated.

COMMENT: One commenter asked what is the time frame for an appeal by a provider or hospital where the -TS modifier was not used initially but the bill is resubmitted.

RESPONSE: The Department does not understand the comment. Appeals can be made when an insurer denies payment for a claim.

COMMENT: One commenter asked the Department to clarify whether the part of the

definition of “trauma services” that states that it does not include transportation to the trauma center means that the ambulance fee schedule would apply even if the transportation to the trauma facility was provided by the trauma hospital ambulance.

RESPONSE: The commenter is correct. “Trauma services” as defined in the proposal does not include transportation to the trauma center in its own ambulance or any other vehicle. Medical transportation has its own fee schedule, Appendix, Exhibit 4.

COMMENT: One commenter requested that the definition of “trauma services” be amended to provide that it does not include, “treatment of a patient discharged from acute care by the attending physician,” rather than referencing “outpatient visits.” The commenter believed this was consistent with the definition of emergency care and would clarify that the trauma exemption did not apply to inpatient services provided to patients once they are discharged from acute care.

RESPONSE: The Department does not agree with the commenter. The Department believes that the definition of trauma services should include inpatient treatment after the patient is admitted the same way that the definition of “emergency care” includes all treatment until the patient is discharged from acute care.

COMMENT: One commenter stated that trauma activation occurs in many cases that do not require such services. The commenter suggested that the rule be amended upon adoption to state, “The decision to activate trauma services must be supported by medical records, else the services are not to be deemed trauma services.”

RESPONSE: The Department does not agree with the commenter. Nothing in the rules prevents a payor from questioning whether the trauma modifier was applied correctly.

The provider should be able to document how the patient met the guidelines for trauma activation.

N.J.A.C. 11:3-29.4

COMMENT: One commenter noted that it was pleased that the proposal clarifies the definition of trauma services and exempts such services from the fee schedule and does not subject them to the reductions for bilateral and multiple surgeries.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter stated that the exemptions from the fee schedule for trauma services provide opportunities for abusive billing practices. The commenter suggested incorporating the American College of Trauma Surgeons guidelines as the basis for qualifying treatment as trauma service. The commenter asserted that the lack of specific trauma guidelines based on defined criteria is potentially detrimental to injured persons. With no limit to allowed charges, a patients' entire $250,000 PIP limit can be exhausted leaving no funds for further patient charges including hospital charges and rehabilitation.

RESPONSE: The Department does not agree with the commenter. The Department believes that the New Jersey Trauma Centers already have guidelines for trauma center activation. The Department requests the commenter to submit specific examples if this is not the case.

COMMENT: One commenter objected to the exemption for trauma services from the restrictions on assistant and co-surgeons contained in N.J.A.C. 11:3-29.4(f). The

commenter stated that the exemption is completely unnecessary since the medical fee schedule limits do not apply to these fees. The commenter went on to state that there was no reason to explicitly permit an additional means of expansion of unregulated fees.

RESPONSE: The Department does not agree with the commenter. The proposal states that the fees in Exhibit 1 do not apply to trauma services but the rule provisions of N.J.S.A. 11:3-29.4 do apply to trauma services except as specifically excepted. Therefore, unless specifically exempted, the restrictions on assistant and co-surgeons would apply to surgeries performed in trauma services.

COMMENT: One commenter asked if it would be appropriate to pay bills that do not have the "-TS" or "-ER" modifiers according to the Physicians' Fee Schedule or UCR whichever is lower.

RESPONSE: The commenter is correct.

COMMENT: One commenter suggested adding a new provision to N.J.A.C. 11:3-29.4(c) to set the fee for durable medical equipment that is not on the fee schedule and for which there is no usual and customary fee at invoice plus 20 percent. The commenter stated that this addition would ensure reasonable fees for all Durable Medical Equipment.

RESPONSE: The Department does not understand how there could be no UCR fee for a piece of durable medical equipment if there was an invoice for it and given the expansive fee schedule for DME. The Department agrees that invoice plus 20 percent might be a reasonable basis for UCR for DME that is not on the fee schedule but would need to study the issue further to determine whether such a provision is necessary.

COMMENT: One commenter noted that reference to a Medicare claims manual provision is unnecessary and confusing to providers.

RESPONSE: The Department does not agree with the commenter. The Medicare Claims Handling Manual and other publications are publicly available and widely followed in the industry since Medicare is the largest health payor and most providers are familiar with it.

COMMENT: One commenter asked the Department to clarify what an insurer should do if a provider billed a code that had been deleted. The commenter asked if the services would not be eligible for payment.

RESPONSE: The answer depends on why the code was deleted. In most cases, a code is deleted from the CPT manual because it is replaced with another code, split into several codes or bundled into another code. In such cases and as required by N.J.A.C. 11:3-29.4(e), the provider should bill the new code. If the provider bills the old code, the payor should reimburse for the new code and advise the provider to bill the new code in the future. If a code was deleted because it has been determined that it no longer described a legitimate medical service, that might be a reason for determining it was not eligible for payment. The Department expects insurers and their vendors to examine the specific circumstances of a bill.

COMMENT: One commenter noted that the provision requires providers to use the most up to the minute codes under the AMA, yet the Commissioner has previously made changes to the AMA codes that do not comport with such codes. For example, when a provider uses a cold laser, which pursuant to the AMA should be CPT 97039, it should be

coded as an infrared therapy device.

RESPONSE: The Department does not agree with commenter. The description of CPT 97039 established by the AMA is "unlisted attended modality," not cold laser treatment. The Department follows Medicare and other payers who reimburse this code under CPT 97026, infrared therapy.

COMMENT: One commenter asked whether the following sentence in N.J.A.C. 11:3-29.4(e), "[t]he amount that the insurer pays for the service shall be in accordance with this subsection" refers to an earlier sentence in the paragraph that states that services not on the fee schedule are payable at the same rate as similar services that are on the fee schedule. The commenter asked if that meant that a new code that replaced a deleted code would be paid at the same rate as the deleted code unless there was a substantive change in the description of the service.

RESPONSE: The commenter is correct.

COMMENT: One commenter asserted that it was premature to require that a provider submit EOBs showing past billings and that the insurer identify the database used to gauge the reasonableness of the provider's bill at the payment stage. The commenter noted that the vast majority of PIP payments do not involve any disputes between the provider and the insurer. The commenter believed that adding this administrative burden would be costly both in terms of time and money and would serve little purpose. The commenter believed that the provision was more appropriate for the appeal stage where a provider is challenging the insurer's payment as UCR. Another commenter noted that while it appears that every time a provider submits a bill, he must attach EOBs to the bill,

the rule then provides that the insurer determines the reasonableness of the provider's fees, which does not consider at all the EOBs that are required to be submitted.

RESPONSE: The Department does not agree with the commenter. N.J.A.C. 11:3-29.4(e)1 does not require that a provider submit an EOB with every bill. The paragraph merely provides a methodology for the establishment of the UCR fee if the insurer disputes what the provider bills for the service.

COMMENT: One commenter asked how a "national" database can be used to meet the statutory requirements that UCR be based on the geographic area in which services are performed. The commenter stated that the rule needs to be specific that the geographical zip code be the same as that of the billing provider.

RESPONSE: The Department does not agree with the commenter. The term "national" databases refers to companies that produce fee databases for the entire country. The Department does not believe that it is necessary to clarify that the insurer must use a fee from such a database that corresponds to the location of the provider.

COMMENT: Several commenters asked for clarification as to whether the information about the UCR database and percentile had to appear on the EOB. One commenter stated that if the information related to the UCR database had to be printed on the EOB, only a generic disclosure of the database and percentile should be required. The commenter suggested that the geographical zip code (geozip) only be provided upon appeal.

RESPONSE: The rule does not require that the information about the UCR database be printed on the EOB. It is up to the insurer to determine how this information is transmitted. The rule only requires that if the insurer supports its determination of the

appropriate fee by use of a national database, it must identify the database used, the percentage, and geozip.

COMMENT: One commenter asked if the provisions of N.J.A.C. 11:3-29.4(e)1 permitting the use of national databases to determine UCR applied only to physician fees or could an insurer use a national database of pharmacy fees. Another commenter requested that the Department specify the exact UCR percentile that should be applied by a carrier. The commenter claimed that would reduce or eliminate inconsistencies in how carriers apply UCR reductions and would also reduce the potential for UCR-related arbitrations.

RESPONSE: The use of national databases is included in the provision of the rule as part of how to calculate the usual, customary, and reasonable fee for services that are not on a fee schedule. The fees for certain drugs are on the Physicians' Fee Schedule but many are not. Therefore, it is appropriate for payors to use a national database to determine drug prices. The Department does not agree that it should establish a UCR percentage. That would be equivalent to setting the fees for such codes and would require separate rulemaking.

COMMENT: Several commenters welcomed the provision that requires insurers to identify the database used as evidence to support the reasonableness of a fee and urged that insurers be required to disclose on their websites their determinations with respect to the usual, reasonable, and customary fees and the database used to support their fee determinations. Another commenter urged that insurers be required to indicate the specific fee amount associated with whatever databases it uses and to state the

methodology used to derive the UCR. This would further transparency and avoid unnecessary arbitration, since the information would be an indicator to the physician as to whether the amount rings true and whether the physician should consider filing for arbitration. The burden should not be on the physician to gather fee information.

RESPONSE: The Department does not agree with the commenters at this time. The Department does agree that providers should know the source of any fees from national databases used by insurers as evidence of the UCR fee. The Department will monitor how the rule works in practice and make any necessary changes in future rulemaking.

COMMENT: One commenter noted that the proposal refers to use of a "usual, customary and reasonable" database, including FAIR Health. The commenter stated that FAIR Health branding information does not include referencing their database as a UCR database and that FAIR Health referred to its product as, "FH RV Benchmark database." Another commenter applauded the Department for using the FAIR Health database as a sanity check on the newly listed fees, stating that this database is the most transparent and independent among the national databases. The commenter urged the Department to use the FAIR Health database as one of their sources on which to calculate UCR fees.

RESPONSE: The Department listed FAIR Health generally as an example of a company that compiles databases of fees. The Department did not reference any particular product sold by FAIR Health.

COMMENT: Several commenters expressed concerns about the use of national proprietary data bases to determine UCR. Databases limited to discounted fee schedules do not approximate UCR fees since no out-of-network fees are included. Commenters

urged the Department to require that each insurer make publicly available, for each database that it uses, the sources of fee information collected, the manner in which accuracy is checked, the verifiability of the data, and whether it is current. The commenters underscored that "prevailing fee" and UCR may be understated if the data on out-of-network payments is not included.

RESPONSE: The Department does not agree with the commenter. The insurer would not have access to some of the information the commenter believes should be included. The Department believes that the insurer should disclose the information included in N.J.A.C. 11:3-29.4(e)1: the name of the database, the edition date, the geozip, and the percentile.

COMMENT: One commenter asked if N.J.A.C. 11:3-29.4(f)1 meant that in a multiple surgery situation providers should bill bilateral surgeries as one payment amount with the -50 modifier.

RESPONSE: The Department believes that the rule states clearly that this is the case.

COMMENT: One commenter noted that CMS deletes codes from the NCCI edits retroactively. So, for example, a code that was added on 10-1-10 is deleted in the 7-1-11 update as being deleted effective 10-1-11. The commenter asked in the case of a provider whose payment was denied pursuant to an NCCI edit that was subsequently deleted, can the provider resubmit the bill for the service?

RESPONSE: The provider can resubmit the bill for the service if the NCCI edits are changed retroactively.

COMMENT: One commenter noted that N.J.A.C. 11:3-29.4(f)6 states that the necessity for assistant and co-surgeons shall be determined by reference to authorities such as the Medicare Physicians' Fee Schedule database. The commenter states the non exclusive language in the rule has caused providers to submit other guidelines such as those from the National Academy of MUA Physicians, which claim authority in a very limited scope of practice and which contradict those of Medicare. The commenter asked what the Department relies on to resolve the issue of contradictory authorities. Another commenter stated that he did not understand exactly where the provider is to look.

RESPONSE: First, the Department notes that the provision of the rule to which the commenter refers was not amended in this proposal except to substitute OSF for ASC and this change is being eliminated in this adoption. Moreover, this is the first time the Department has been made aware of this issue. The Department will address the issue in future rulemaking by stating the specific authorities that can be used to make these determinations.

COMMENT: One commenter stated that single use surgical instruments should not be separately billed as provided by N.J.A.C. 11:3-29.4(f)8. The commenter believed that these instruments are simply part of the surgery and their reimbursement should be included in the fee for the surgery. The commenter also requested more clarification about the reimbursement rates based on the invoice price. The commenter suggested that insurers be able to require that the provider supply a copy of the invoice upon request. Another commenter suggested amending the rule upon adoption to add the phrase "manufacturers invoice cost" to clarify the term invoice. The commenter further recommended that the invoice must be from a supplier and not from the facility rendering

the service. The commenter also stated that the provider needs to clearly identify which implants and/or other devices are chargeable to the patient. The commenter noted that invoices often include items used for multiple patients. This commenter also suggested amending the rule upon adoption to add the following language, "... shall be reimbursed at the lesser of the manufacturer invoice price or the cost of the facility to acquire the item plus 20 percent." The commenter also recommended that the phrase "or attached" be removed from N.J.A.C. 11:3-29.4(f)8 to be consistent with current regulations. Finally, the commenter recommended adding language to the rule upon adoption to state that unless the invoice is supplied, the cost of the implant is not reimbursable.

RESPONSE: The Department does not agree with the commenter that single-use surgical instruments should not be separately billed. The Department included them in rule based on information from payors that these items are often billed separately. The Department appreciates the suggestions of the commenters for improvements to the language but notes that most of the suggestions would constitute substantial changes requiring additional notice and public comment. The Department prefers to see how this new requirement works in practice and make changes in future rulemaking to address issues that occur. At base, it is a very simple requirement – the provider should be able to show what it paid the manufacturer or distributor of the device that is being implanted in the patient. That amount plus 20 percent is what that insurer should reimburse.

COMMENT: One commenter objected to the proposed language limiting the ability of providers to adequately bill for implants and prosthetics. The commenter stated that billing for PIP-covered patients hospitalized for emergent trauma care or subsequent hospitalizations for reconstructive trauma surgery at a New Jersey Level One Trauma

Center should be exempt from the proposed language in N.J.A.C. 11:3-29.4(f)8 pertaining to implants and prosthetics. Among the items subject to this proposed language are neuro-stimulators, internal and external fixators, single use spine wands and spine probes, tissue grafts, plates, screws, anchors, and wires. This new limitation would apply to trauma and inpatient surgery settings, would be a significant reduction of current reimbursement, and would require submission of invoices whenever an insurer is billed for a scheduled implant or prosthetic. The commenter seeks deletion of the last sentence in paragraph (f)8 to maintain the intent of exempting trauma services from the fee schedule; or at least the exclusion of "trauma centers" from the proposed language since prosthetic and other implants would likely occur in connection with a trauma center activation. Level One Trauma Centers must provide necessary financial support to maintain clinical infrastructure and physician specialty expertise that is not required of Level Two Trauma Centers. The only financial means available to support Level One Trauma services is the maintenance of adequate commercial payment rates to cover the trauma admitting area, intensive care unit and physicians with expertise in over 40 medical and surgery subspecialties available within an hour's notice on a 24/7basis.

RESPONSE: The Department does not agree with the commenter. The Department recognizes that treatment in trauma units costs more than non-trauma care because of the extraordinary resources that are maintained ready to treat critically injured patients. However, the additional costs of trauma care do not extend to the costs of implantable devices. The Department does not believe that there is any basis to exempt trauma hospitals from the provisions of this rule. The limits of a patient's PIP coverage can be exhausted very rapidly when their injuries mandate activation of a trauma unit. Those

claim dollars should be directed to the higher costs associated with such care.

COMMENT: One commenter stated that the most critical concern for the hospital community relative to this proposal is the preservation of funding necessary to maintain the State's crucial trauma system. Motor vehicle crashes nationwide account for the majority of trauma center patients. Because there is no dedicated public funding source for the trauma system, the New Jersey trauma centers require adequate PIP reimbursement to remain responsive.

RESPONSE: The Department agrees with the commenter and acknowledges that reimbursement for PIP patients subsidizes New Jersey's trauma hospitals. However, as noted above in the Response to another Comment, the additional reimbursement should be directed at services provided in trauma centers that have a higher cost.

COMMENT: One commenter requested that the last sentence of N.J.A.C. 11:3-29.4(g) be amended upon adoption to include AMA Guidelines along with the other sources cited for interpretation of the fee schedules.

RESPONSE: The commenter's suggestion would constitute a substantial change requiring additional notice and public comment. The Department will review the AMA guidelines to see if they should be included in the list of sources for interpretation of the fee schedules in a separate rulemaking.

COMMENT: One commenter objected to the use of the NCCI edits. The commenter noted that the edits were expressly drafted because of the belief that it was inappropriate for a provider to be separately compensated for certain services when provided together at the same time. The commenter stated that now a daily cap is being applied, which is

accounting for physicians not being compensated for procedures regularly being done together, but this is actually being applied twice with the NCCI edits in force. The commenter also noted that the Medicare system does not have a daily cap and there is no justification for applying both of these rules. Another commenter noted that the NCCI edits are used in determining whether a provider has reached the daily maximum, which is an inappropriate additional reduction.

RESPONSE: The Department does not agree with the commenters. The NCCI edits address unbundling, the practice of separating one procedure into multiple parts to increase the amount billed. There has always been a prohibition of unbundling in the fee schedule rule. The NCCI edits are simply a more comprehensive methodology for preventing unbundling. The daily maximum permits the Department to set a single fee for a group of the same type of services that are commonly performed together in one treatment session. It addresses a different kind of unbundling where providers add more and more services to a visit in order to increase the fees paid specifically for physical medicine services that were previously billed on a per visit basis. If the CPT codes that are included in the daily maximum are also subject to the NCCI edits, it is appropriate to apply the NCCI edits because the NCCI edits indicate that one service is included in the other.

COMMENT: One commenter noted that N.J.A.C. 11:3-29.4(g) states that the fee schedules shall be interpreted in accordance with the Medicare Claims Processing Manual. The commenter stated that the Manual requires the use of various forms to submit bills and asked if insurers will deny PIP claims that were submitted on a HCFA 1500 if Medicare requires use of a different form.

RESPONSE: The Department does not agree with the commenter. "Interpreted in accordance with the Medicare Claims Processing Manual" does not mean that the Department is adopting the Medicare forms and payment system. It means that the Department is incorporating the information in the Medicare Claims Processing Manual about how the treatments represented by the various codes are to be performed.

COMMENT: One commenter recommended requiring the provider to submit documentation to the insurer to support the use of modifier -59 when bills are submitted to the insurer. This would provide the insurer the opportunity to confirm that the requirements to use the modifier were met.

RESPONSE: The Department agrees with the provider and believes that the adopted amendments require that such documentation be submitted to support any use of a -59 modifier.

COMMENT: One commenter strongly supported N.J.A.C. 11:3-29.4(g)3, which states that x-ray digitization or computer-aided radiographic mensuration is not reimbursable under PIP.

RESPONSE: The Department appreciates the support.

COMMENT: The Department received 223 form letters from commenters opposed to the proposal, asserting that N.J.A.C. 11:3-29.4(g)3 will have a detrimental affect on New Jersey insureds and injured patients. The commenters noted the proposed changes include many new restrictions on patients and doctors, one of which is the proposal that Computerized Radiographic Mensuration Analysis (CRMA) will not be reimbursed by auto insurers because, as stated in the notice of proposal, "It does not provide any

additional information than regular x-rays." The commenters assert that this statement is false. They state that CRMA provides very valuable information no other test can provide and measures all different degrees of spinal ligament injury, which cannot be done by visual inspection, hand measurement, or any other way, according to strict AMA Guidelines. They further assert CRMA is one of the very few tests that prove ligament injury with accuracy and objectivity and that, because it prevents misdiagnosis and streamlines care, excluding this valuable test will cost consumers much more money in the future, which would be devastating for people injured in auto accidents in New Jersey as well as more costly for insurers.

The commenters then listed the following as other insurer benefits attributable to CRMA: provides the most accurate way to determine how a policy may apply to a specific condition; provides the most accurate measurement possible, confirming or denying findings which qualify for consensus-driven impairment from the AMA Impairment Guides, rather than the opinion of a treating doctor; protects policy-holders from unnecessary tests and treatment which increase the cost of recovery; prevents additional costs from misdiagnosis, eliminates the need for future, more costly testing; and reduces human error in x-ray interpretation, leading to more accurate diagnosis, resulting in more accurate and efficient treatment protocols that reduce recovery time.

The commenters stated that all of these benefits are produced for less than the cost of an MRI or other test which cannot reveal this essential information. They further noted that many doctors, from many sub-specialties, use this well-established objective procedure when indicated for patients that are post-traumatic with an indication of possible spinal ligament insult, and that the CRMA report and technology behind it has

been used in (a non-New Jersey) court as expert scientific evidence as recently as December 21, 2010.

The commenter also stated that it has been established that CRMA meets the Daubert Criteria for reliability, is used clinically, and is well established as being "consistent with commonly accepted protocols and professional standards of care." The commenter also supplied statements from the "2003 CCP Guidelines" supporting the test as an accepted protocol and standard of care, including:

"Hand mensuration…cannot approach the accuracy attainable with advanced computer technology. CRMA provides mechanical analysis with a high degree of accuracy in order to make Chiropractic differential diagnosis and or determine care protocols" and "CRMA may be used to objectively analyze the biomechanical improprieties related to vertebral subluxation. Clinical necessity is justified for assessing the degree of insult and the effect on the patient's health and future well-being…"

The commenters asked that the Department reconsider inclusion of CRMA as part of diagnostic testing for spinal ligament assessment for the good of policyholders and for cost-containment reasons. Other commenters also strongly objected to the proposed exclusion of PIP reimbursement of x-ray digitization and computer radiographic mensuration analysis. The commenters disagree with the Department's Summary statement that "These procedures do not provide any additional information than a regular X-ray." The commenters noted that New Jersey would become the only state that prohibits PIP reimbursement for computer radiographic mensuration analysis and that CRMA is a unique analysis that provides the most accurate, objective assessment of the

extent of ligament injury and is paid for by workers compensation carriers and numerous health insurance carriers. There is widespread scientific support for its use. The commenters noted that insurance carriers have recognized the value of the test to achieve cost containment goals and accuracy in medical diagnosis and treatment.

RESPONSE: The Department does not agree with the commenters. The Department notes that the American Medical Association (AMA) has not established a CPT code for the technique, which is a prerequisite for its reimbursement. Well-designed clinical trials supporting efficacy are lacking in the medical literature and there is insufficient evidence to support the assertion that the use of this technology adds any benefit or improvement of health outcomes when compared to standard diagnostic and chiropractic techniques. If the AMA establishes a CPT code for this technology, the Department will consider including it in the fee schedule.

COMMENT: Several commenters lamented that the proposed rules will no longer allow for reimbursement for kinesiotaping and maintained that kinesiotaping is a separate, distinct modality apart from chiropractic adjustment or other therapies, and should remain eligible for separate reimbursement and that the bundling of this treatment into another code is objectionable and was proposed without consultation with the Board of Chiropractic Examiners or any other licensed New Jersey chiropractors. One commenter stated that N.J.A.C. 11:3-29.4(g)4 was confusing. If kinesiotaping is not reimbursable, the commenter asked why coding issues should be addressed in the paragraph. The commenter noted that kinesiotaping is sometimes billed under the HCPCS code for the tape and sometimes using an unlisted code. Another commenter requested that N.J.A.C. 11:3-29.4(g)4 be amended upon adoption to read (addition in boldface):

"Kinesio taping or other taping is not reimbursable under PIP**. Kinesio taping shall not be billed under any code. For purposes of example, and not limitation,** Kinesio taping shall not be billed using the strapping codes, CPT 29200 through 29280 and 29520 through 29590."

One commenter stated that the wording should be changed to read that "strapping" properly coded under CPT 29200 through 29280 and 29520 through 29590 is proper, "when used for immobilization, precasting, pre/post surgically."

RESPONSE: The Department does not agree with the commenters. The American Medical Association has not seen fit to create a CPT code for kinesiotaping, which is a prerequisite for its separate reimbursement. If the AMA establishes a CPT code for this treatment, the Department will consider including it in the fee schedule.

The Department acknowledges that it may be a useful technique but its use to treat injuries from motor vehicle accidents is included in other therapeutic procedures. The Department also does not agree with the commenters' suggestion for changes to the language of N.J.A.C. 11:3-29.4(g)4. The Department believes that the language stating that kinesiotaping is not reimbursable is necessary because some providers have tried to bill for kinesiotaping using the CPT codes for strapping. The Department also believes that it is not necessary to add a description of strapping since the description of these codes is already in the CPT manual.

COMMENT: One commenter suggested that it was necessary to include a definition of "chronically injured tendon" in the rule because medical resources differ on the definition of this condition. The commenter recommended that the rule be amended upon adoption

to define a condition as “chronic” if there is no change in condition or symptoms for three months.

RESPONSE: The change suggested by the commenter would constitute a substantial change requiring additional notice and public comment. The Department believes that the use of the term “chronic” is generally known in the medical community. If additional clarification is necessary, the Department will add a definition in future rulemaking.

COMMENT: One commenter recommended that the rule be amended upon adoption to state that Platelet Rich Plasma (PRP) should not be billed when any other surgical procedure is performed.

RESPONSE: The change suggested by the commenter would constitute a substantial change requiring additional notice and public comment. The Department will review the use of this code to determine if additional guidance on the use of this procedure is necessary.

COMMENT: One commenter suggested that the rule be amended upon adoption to state that HCPCS code 0232T is all inclusive of the PRP procedure and includes harvesting blood, preparation, etc. The commenter believes that there should not be any separate billing for the components of PRP, and in particular that CPT codes 36513, 36514, and 32806 are, by definition, not part of the PRP procedure.

RESPONSE: The Department does not agree with the commenter. The definition of the procedures as adopted by the AMA includes the following information: “0232T—Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed (Do not report 0232T in conjunction with 20550, 20551,

20600-20610, 20926, 76942, 77002, 77012, 77021, 86965.)." The additional codes suggested by the commenter would constitute a substantial change requiring additional notice and public comment. The Department will review the use of this code to determine if additional guidance on the use of this procedure is necessary.

COMMENT: Several commenters identified a grammatically incorrect sentence in N.J.A.C. 11:3-29.4(g)7. The commenters believed that the sentence ought to read (additions in boldface; deletions in brackets):

"Where a provider in a different practice or facility [makes] **performs** a medically necessary review[s] **of** an imaging study…"

Another commenter stated that its interpretation of 76140 is that the code is not reimbursable and is not on the fee schedule. The commenter notes, however, that N.J.A.C. 11:3-29.4(g)7 states that a provider may bill this code if a modifier -26 is applied, which would note that a provider may bill the professional component for each specific radiology service, which the commenter stated would occur very rarely.

RESPONSE: The Department agrees with the commenter and has amended the rule upon adoption to correct the grammatical error. The Department does not agree with the commenter's interpretation of N.J.A.C. 11:3-29.4(g)7. CPT 76140 is a code for the review of an imaging study. N.J.A.C. 11:3-29.4(g)7 states that when a provider from a different practice or facility reviews an imaging study, that provider should bill the professional component of the CPT code for the specific imaging study that was performed and not CPT 76140.

COMMENT: One commenter stated that the prohibition on a provider billing for an

office visit and interpretation of an imaging study will be used by insurers to split the components of an x-ray taken in the physician's office and try to pay the physician for the technical component only. The commenter recommended that the rule be clarified to state that it only applied to images from sources outside the office.

RESPONSE: The Department does not agree with the commenter. The part of the rule cited by the commenter was not amended in the proposal and applies to imaging studies where the provider has already billed the technical and professional component of the imaging study. The purpose of the rule is to prevent double reimbursement for interpretation of the imaging study.

COMMENT: One commenter noted that N.J.A.C. 11:3-29.4(g)9i restricts the reporting of HCPCS code G0289 unless the physician spent at least 15 minutes in the additional compartment performing the procedure. The commenter observed that operating room notes give only the total time for surgery and do not break down the time spent for each coded item. The commenter suggested that the rule be amended upon adoption to require that the code is only payable with documentation in the operative notes of the requisite 15 minutes.

RESPONSE: The Department notes that the descriptions of CPT codes 29880 and 29881 were changed in the 2012 edition of the CPT manual to include the chondroplasty covered by G0289. Making this change on adoption would be a substantial change requiring additional notice and public comment. Payors and providers should follow the guidance in N.J.A.C. 11:3-29.4(e) for codes that have changed since the rule was adopted.

COMMENT: One commenter objected to the limits on reimbursement of the manipulation of multiple regions of the spine under anesthesia. The commenter believes that the Department has incorrectly interpreted language used in the CPT 22505. Specifically, the commenter asserted that “any region” permits the code to be used when manipulating any region of the spine; it does not mean that the code should be used once for all regions on which manipulation is performed on a given service date. Another commenter stated that no adjustment to the fee schedule has been made to reflect the fact that generally providers treat the three areas of the spine and, as such, it would appear that the previous rate should be multiplied by three.

RESPONSE: The Department does not agree with the commenters. The Department’s determination that CPT 22505 can only be reimbursed once is supported by the CPT Assistant March 1997 Volume 7 Issue 3 "Musculoskeletal, 22505 (Q&A) How would you code manipulation of the spine under anesthesia for the specific areas of the spine (ie, cervical, thoracic, and lumbar)?” AMA Comment, From a CPT coding perspective, code 22505, Manipulation of spine requiring anesthesia, any region, should be reported only once, for any and all regions manipulated on that date.

COMMENT: Several commenters expressed support for the increases in the daily maximum.

RESPONSE: The Department appreciates the support.

COMMENT: Several commenters noted that by limiting reimbursement of the separate modalities that are subject to the daily maximum, the Department may in effect be denying care. The limited compensation will force many independent practitioners to

close, and the commenters urge the Department to consider the impact on these jobs. One commenter, in light of the Jobs Impact statement requesting comments upon the impact of the proposed rules on jobs, offered to participate in further discussions with the Department about appropriate reimbursement rates and the potential negative effect these fee schedules will have on chiropractic offices. The Department invites the commenter to submit information about the economic effect of the daily maximum in relation to the fees paid for these services by other health payors.

RESPONSE: The Department does not agree with the commenters. The daily maximum fee has been in effect for many years. The Department has raised the amount of the daily maximum each time it has amended the Medical Fee Schedule rule. The Department notes that the daily maximum is higher than what many health insurers pay for these services. In addition, there are no limitations in PIP on the number of visits for chiropractic treatment as there are in many health policies.

COMMENT: One commenter stated that the current language in this provision allows for reimbursement in excess of the daily maximum in certain situations. The commenter noted that there are few instances when more than the daily maximum is paid to a provider. The commenter suggested another possible method would be a specific “carve out” and recommended that the Department add language to this provision to exempt from the PIP Physical Medicine and Rehabilitation Daily Maximum treatment delivered in a hospital-based outpatient setting for severe injuries that commonly require more than two units of therapy a day. The commenter provided examples of ICD-9 codes for these types of injuries.

RESPONSE: The change recommended by the commenter would be a substantive change requiring additional notice and public comment. The Department agrees that exempting the treatment of certain injuries from the cap might be feasible. The Department will review the information provided by the commenter, consult with interested parties, and may amend the rule to include such diagnoses in future rulemaking.

COMMENT: One commenter asked, "Confirm reimbursement of anesthesia qualifying circumstances (99100-99140 add on codes). Current Medicare guidelines consider these codes unbundled (status B)."

RESPONSE: The Department does not understand the comment. There is no reference to bundling in the Medical Fee Schedule.

COMMENT: One commenter, referencing N.J.A.C. 11:3-29.4, asked, "Clarify use of benchmark data. Is it restricted to charge based data or allowed based data or both?"

RESPONSE: The Department's rule does not specify what type of national databases of fees a payor can use. However, all the publicly available databases are charged-based data.

COMMENT: One commenter, referencing N.J.A.C. 11:3-29.4, asked, "Clarify whether effective date is policy effective date driven."

RESPONSE: The notice of adoption for this rule specifies that most of the rule is operative 60 days from the effective date. However, those portions of the rule containing the internal appeal process will not be operative for 365 days. In addition, some

provisions of the rule require that insurers make changes to their DPR plans, which would be effective on the date requested in the filing.

N.J.A.C. 11:3-29.5

COMMENT: One commenter, referencing N.J.A.C. 11:3-29.5, asked, "Assumption that if no facility or ancillary fee billed by OSF exists in fee schedule, pricing should default to benchmark data. If no fee exists in either fee schedule or benchmark data, how are these to be handled?"

RESPONSE: The Department believes that N.J.A.C. 11:3-29.5(a) clearly states that if there is no facility fee listed for a code, the service cannot be performed in an ASC. As noted in the Response to an earlier Comment, the Department has proposed substantial changes to its initial proposal that create separate ASC and HOSF facility fee schedules, but the same rule applies to ASCs: if there is no facility fee for a code on the ASC fee schedule, the service is not reimbursable if performed in an ASC.

COMMENT: One commenter, referencing N.J.A.C. 11:3-29.5, asked, "Confirm ancillary services that are not flagged as packaged codes (N1) are separately reimbursable or if current Medicare ASC payment indicators can be used to determine whether or not a code is considered packaged as noted in 11:3-29.5(a)-4."

RESPONSE: The Department is not aware of any payment indicators for packaged services other than the N1 designation included on the fee schedules. The Department requests information from the commenter about such other payment indicators that may exist.

COMMENT: One commenter, referencing N.J.A.C. 11:3-29.5, asked, "Guidelines reference bilateral procedures performed in one session are to be reported as two procedures and subject to multiple procedures reduction (i.e. 64490). This conflicts with AMA guidelines. Confirm appropriate handling."

RESPONSE: The Department does not agree with the commenter. The AMA guidelines refer to physician billing of bilateral procedures. N.J.A.C. 11:3-29.5 refers to the facility fees for these procedures.

COMMENT: One commenter, referencing N.J.A.C. 11:3-29.4(g), asked, "Confirm guidelines referenced in attached links are appropriate for handling TENS rental and/or purchase.

https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleid=37219

https://www.cms.gov/medicare-coverage-database/details/icd-details.aspx?LCDld=11506."

RESPONSE: The Department is unable to respond because the links provided by the commenter are not valid.

COMMENT: One commenter noted that N.J.A.C. 11:3-29.4(g)11 references a list of procedures in the CPT Manual for which conscious sedation cannot be billed separately. The commenter requested that the rule be amended upon adoption to confirm that conscious sedation is able to be billed separately when multiple procedures are performed, one of which is a procedure for which conscious sedation cannot be billed

separately but other procedures are not subject to this limitation.

RESPONSE: The change requested by the commenter would be a substantial change requiring additional notice and public comment. The Department notes that the commenter did not provide a reference to any authority such as CMS to support such a change. The Department will review the suggestion to see if it is appropriate and, if so, will include it in future rulemaking.

COMMENT: One commenter, referencing N.J.A.C. 11:3-29.4(g), stated, "There are no payment guidelines for handling DMEPOS payment classes OS (Ostomy, Tracheotomoy and Urological); S/D (Surgical Dressing); or SU (Supplies, DME) within Medicare Claim Processing Manual. Please confirm recommended handling for these payment classes are in accordance with fee schedule allowance."

RESPONSE: The Department does not understand what, "Please confirm recommended handling for these payment classes are in accordance with fee schedule allowance," means. N.J.A.C. 11:3-29.4(g) instructs payors to follow the relevant Medicare payment guidelines. If such guidelines do not exist, payors should follow the rules for payments at the UCR rates.

COMMENT: One commenter expressed its support for the increase in most rehabilitative therapy rates, including 97001, 97003, 97110, 97112, 97140, 97116, 97535, 97760, and 97532.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter noted that N.J.A.C. 11:3-29.5(a) restricted outpatient

procedures to those approved on an outpatient basis by the CMS. The commenter suggested that as CMS approves additional procedures to be performed on an outpatient basis, they should be added to the Physicians' Fee Schedule at a set percentage of the Medicare rate.

RESPONSE: The Department agrees with the commenter and intends to make regular updates to the fee schedule rules to reflect changes in CPT codes and Medicare rules.

COMMENT: Two commenters asked if OSFs should bill using a HCFA form rather than a UB-92, since UB-92s are solely designed for facilities and are required for billing Medicare.

RESPONSE: The Department has not specified what forms providers should use to bill for their services. As noted above in the Response to another Comment, the Department does not require that providers or insurers use Medicare billing forms or practices.

COMMENT: One commenter asked if the limitation on the services that can be performed in an OSF applies to non-emergency situations only. The commenter and others also asked if it was appropriate to reimburse zero to an OSF if a procedure was performed there that has a fee in the physicians' fee column but it does not have a fee on the OSF fee column. The commenter asked in addition if the "similar service" rule at N.J.A.C. 11:3-29.4(e) applies to the above examples. Finally, the commenter referenced language in the section that refers to the OSF fee including services that would be covered if the services were provided in a hospital. The commenter asked if it was the Department's intent to reimburse both inpatient and outpatient services according to the OSF fee schedule.

RESPONSE: As noted above in the Response to another Comment, the Department has proposed substantial changes to its initial proposal, including a HOSF Fee schedule along with associated rule changes. As part of those changes, the Department is clarifying that the HOSF Fee Schedule only applies to non-emergency-room outpatient treatment. The Department has been made aware that the Emergency Room in a hospital is considered as part of its outpatient department. The proposed substantial changes make it clear that the Hospital Outpatient Surgical Fee Schedule, including the limitations on services that can be provided in a HOSF, do not apply to surgical procedures performed in a hospital emergency room.

In the proposed substantial changes, the Department also clarifies that the similar service rule at N.J.A.C. 11:3-29.4(e) only applies to physicians' fees.

COMMENT: Several commenters stated that DOBI's distinction between procedures that may be performed in an OSF and those that may not is based on utilizing the determination of CMS with respect to the Medicare coverage of procedures performed in an ASC. The commenters believe that this is a flawed approach that should be abandoned for the following reasons: by applying the Medicare ASC coverage standards to procedures performed in a hospital outpatient department, DOBI is prohibiting the performance of outpatient procedures in a HOPD under PIP that are covered by Medicare when performed in an HOPD; CMS's determination with respect to the coverage of ASC procedures under Medicare should have no bearing on the PIP fee schedule, which governs private insurers and insurance benefits of the general population rather than the limited elderly and disabled Medicare population who have significantly different needs to be considered in determining whether a procedure could safely be performed in an

ASC and covered under Medicare; and the application of Medicare ASC coverage standards to the PIP fee schedule is an inappropriate interference with medical decision-making, inhibits the performance of medically necessary treatments, and DOBI is without legal authority to regulate these matters. Several commenters stated that many of the procedures that appear on the Medicare Hospital Outpatient Department fee schedule were either left off of the fee schedule entirely or did not have an amount in the outpatient surgical facility column, which means that such a procedure could not be performed in an OSF. Several exhibits were submitted with the comments to support the claims of non-inclusion of procedures or procedures with no amount in the outpatient surgical facility column. By failing to include such procedures on the proposed schedule, patients will be forced to have their procedures performed at a hospital, thereby increasing their health care cost and those of the insurer. The commenter noted that the implementation of the proposed fee schedule, with its limited procedure list for OSFs, will adversely impact accident victims and severely limit their ability to access surgery at an OSF. One commenter noted that the proposal is a harsh departure from the status quo, which balances the issues of access to care and cost while, at the same time, providing flexibility for advancements in medical technology that have allowed a growing range of procedures to be performed safely on an outpatient basis.

The commenter noted that there are many procedures on Medicare's HOPD fee schedule that are not included in the proposed PIP fee schedule. The commenter provided exhibits listing specific examples of procedures that could no longer be performed in an ASC, as well as those that are on the HOPD schedule but not on the PIP schedule. Several commenters opined that limiting access to ASCs serves no discernable public policy goal,

while depriving consumers of utilizing safe, efficient facilities of their choice. The commenter recommended that the current process for reimbursing unlisted procedures remain the same, and payment for the procedures on the HOPD schedule should be included on the fee schedule. Another commenter noted that the Department has created the OSF by merging ASC, HOPD, and office-based procedures, although each has its own CMS Fee Schedule and hence its own list of procedures that can be performed in each of these settings. The notion that the Department added 2,000 codes and that payments for procedures were raised is not accurate. Additional codes are simply the by-product of the wholesale adoption of the CMS 2011 ASC Fee Schedule as the OSF, and the increased payments reflect the differences between CMS 2011 and 2006/07.

RESPONSE: The Department addressed many of these concerns in the amendments proposed in the notice of proposed substantial changes upon adoption, which creates separate ASC and Hospital Outpatient Surgical Facility Fee Schedules. The Department has responded to the comments concerning the procedures that are not reimbursable if performed in an ASC in the responses to the comments received on the notice of proposed substantial changes upon adoption, which are set forth above.

COMMENT: One commenter stated that Level One Trauma Centers should be exempt from the "Outpatient Surgery Fee Schedule" for trauma patients receiving reconstructive trauma surgery in PIP-covered hospital care following their initial hospital stay for trauma services. The proposed regulation, consistent with Medicare, renders certain ancillary services, previously reimbursed on a UCR basis, ineligible for separate reimbursement. PIP will now pay a facility fee equal to 300 percent of the 2011 Medicare fee schedule for outpatient surgeries, which will significantly reduce the

payment for a trauma patient's follow-up outpatient surgeries.

RESPONSE: The Department does not agree with the commenter. The Department recognizes the additional costs of having specialists on hand waiting for the critically-injured patient in a trauma unit. However, the commenter has not provided any evidence as to why the fee schedule should not apply once the patient is discharged from acute care. Scheduled outpatient surgery for a former trauma patient should not require more resources than the same surgery for any other patient. In addition, limiting the exemption from the fee schedule for trauma care to that provided when the trauma unit is activated helps preserve the benefits of the patient's PIP coverage.

COMMENT: One commenter asked the following: "ER visit (rev code 450) with no surgical procedure – confirm if subject to physicians' fee schedule as currently described in existing fee schedule." The commenter also asked, "ER visit (rev code 450) with surgical procedure (rev code 36X) – confirm is subject to OSF fee schedule."

RESPONSE: The Department does not understand the comment. The fee schedule does not include any "rev codes."

COMMENT: One commenter noted that the proposal states that for OSF fees, there is no difference in payment regardless of where the service is performed. The commenter stated that it was unclear how physicians with office-based surgery will identify facility fee versus professional fee.

RESPONSE: The Department notes that in the notice of proposed substantial changes upon adoption, it deleted the OSF fee schedule and proposed separate ASC and Hospital Outpatient fee schedules. The notice of proposed substantial changes upon adoption also

limited the ability to charge facility fees to ASCs, as defined in the proposal, and hospital outpatient facilities. The definition of ASC from the previous version of the rule has been added. According to that definition, the only office-based surgical facilities that are considered ASCs are those that are certified by Medicare.

COMMENT: One commenter requested confirmation that diagnostic and therapeutic services (7000 series radiology CPTs and 8000 series Pathology and Laboratory CPTs) performed as part of an outpatient surgery for which there is a facility fee on the Physicians' Fee Schedule are included in the OSF fee schedule.

RESPONSE: As noted above in the Response to another Comment, the Department proposed a separate Hospital Outpatient Surgical Facility Fee Schedule, as part of a notice of proposed substantial changes upon adoption. The HOSF Fee Schedule does contain fees for radiological services (7000 series) but not pathology and laboratory services (8000 series.) The notice of proposed substantial changes also proposed a separate ASC Fee Schedule, which, like the current ASC Fee Schedule, does not contain a facility fee for either of these types of procedures.

COMMENT: One commenter noted that his practice performs outpatient laminotomy/discectomies CPT codes 63020 to 63082 and that patients are optimally served. These codes are not listed on the OSF fee schedule and would therefore be forced to be performed in an inpatient setting, which is significantly more costly. Additionally, there are no outpatient facility codes for anterior cervical discectomy and fusion as well as cervical disc replacement which is routinely performed as an outpatient, CPT codes 22600, 22548, 22552, 22595, and 22856.

RESPONSE: The Department addressed many of these concerns in the amendments made in the notice of proposed substantial changes, which create separate ASC and Hospital Outpatient Fee Schedules, and are adopted herein as changes upon adoption. The Department has responded to the comments concerning the procedures that are not reimbursable if performed in an ASC in the Responses to the Comments received on the notice of proposed substantial changes set forth above.

COMMENT: One commenter urged the Department to clarify how the fee schedule would apply, if at all, to a hospital facility charge for PIP outpatient services. Presently an insurer may be billed separately by a hospital for the professional service and use of the facility. The commenter provided the example of when physical therapy services are performed in a hospital setting, the hospital bills for the physical therapy under the code "UB04," which indicates the portion attributable for the use of the facility. The commenter stated that it was not clear how these services would be reimbursed. The commenter urged the Department to illustrate how the fee schedule would be applied in a hospital outpatient setting.

RESPONSE: The Department addressed this concern in the amendments made in the notice of proposed substantial changes, which create separate ASC and Hospital Outpatient Fee Schedules, and which are adopted herein as changes upon adoption.

COMMENT: One commenter asked the Department to clarify whether the inclusion of anesthesia in the OSF facility fee also includes anesthetic pain injections given at the end of surgery.

RESPONSE: The Department's rules do not address this specific issue. The Department

notes that anesthesia is not on either the ASC or the HOSF fee schedules. Anesthesia services are on the Physicians' Fee Schedule. The Department recommends that the commenter consult the reference materials listed in the rule at N.J.A.C. 11:3-29.4(g) for guidance on this issue.

COMMENT: Several commenters noted that the rules for payment of OSF fees state that where multiple procedures are performed, the first procedure is paid at 100 percent and the remaining procedures at 50 percent. The commenters believed that there is little or no additional costs for the facility where the additional procedures are in the same Ambulatory Payment Classification (APC), and questioned the procedure. The commenters recommended following the New York Workers Compensation fee schedule rule for services in the same ambulatory surgical group, which provides that only one fee is payable. Another commenter recommended that the Department retain the existing bilateral billing procedures for an OSF. The commenter noted that under the Department's proposal, bilateral procedures performed in the same operative session in an OSF are to be reported as two procedures and will be subject to the multiple procedures reduction formula. However, the rule for physicians billing multiple procedures is to bill once using modifier -50. The commenter asked what the Department's rationale was for making the change and establishing two different procedures for billing multiple procedures. One commenter also inquired why several codes that are known as "additional level' or "add-on" codes are included in the proposed multiple procedure reduction. The commenter noted that reimbursement for the procedures represented by these codes, such as 64491, 64492, 64494, and 64495, is already substantially reduced by Medicare and should not be subject to an additional 50

percent reduction as the rule suggests. Other commenters noted that there are several procedures (injections by and large) that have codes for additional levels. They are not, and should not be, treated as multiple procedures and reduced by 50 percent, because they are already reduced by CMS on their fee schedule.

RESPONSE: The Department does not agree with the commenters. The Department follows Medicare rules for multiple procedures. The Department notes that the Medicare rules are different for physician services and the facility fees for ASCs in Exhibit 1 and the facility fees for hospital outpatient surgical facilities in Exhibit 7.

COMMENT: One commenter stated that N.J.A.C. 11:3-29.5(c)1, which states that a procedure that is performed bilaterally in one operative session is reported as two procedures and is subject to the multiple procedures reduction formula, should be amended to clarify that this provision does not apply to radiology codes that are inherently bilateral.

RESPONSE: The Department does not agree that a change is necessary. The rules for bilateral procedures clearly refer to surgical procedures, not radiology.

COMMENT: One commenter asked if it was the Department's intention that outpatient surgical facilities follow Medicare guidelines for billing bilateral procedures in separate lines with modifiers "-RT" and "-LT" to properly identify a bilateral procedure that was performed at a facility or should the OSF use a modifier "-50" as is done by physicians.

RESPONSE: The Department does intend to have ASCs and HOSFs follow Medicare guidelines. However, the Department is not aware of any Medicare rule concerning the billing of bilateral procedures for ASCs and HOSFs other than the multiple procedure

reduction formula rule contained in newly adopted N.J.A.C. 11:3-29.5(d).

COMMENT: One commenter stated that N.J.A.C. 11:3-29.5(c)1 is contrary to the rules for physicians, which provide that it should be billed once at 150 percent.

RESPONSE: The Department does not agree with the commenter that N.J.A.C. 11:3-29.5(c)1 is contrary to the physicians rule. The Medicare rules for ASCs and HOSFs are different than those for physicians and are as stated in the proposal.

COMMENT: One commenter stated that subjecting bilateral procedures to the multiple procedure reduction formula was grossly unfair to the physician. The commenter claimed that the same amount of time is required to do each procedure and there is no rational reason to reduce the amount paid.

RESPONSE: The Department does not agree with the commenter. The Department follows Medicare rules for how surgical procedures should be billed. The Department also notes that the existing rule contained a similar provision.

COMMENT: Once commenter stated that the proposal referenced the Medicare ASC fee schedule and asked for confirmation that the intent was to use the most recent Medicare fee schedule for applicable rules and fees.

RESPONSE: The Department does not understand the comment. The proposal at N.J.A.C. 11:3-29.4(g) states that the fee schedules shall be interpreted in accordance with the version of the Medicare Claims Handling Manual that was in effect when the service was performed.

N.J.A.C. 11:3-29 Appendix, Exhibit 1

COMMENT: One commenter noted that many of the procedures on the Physicians' Fee Schedule that have an OSF fee associated with them also can be billed with professional (-26) and technical (-TC) modifiers. The commenter did not believe that in such cases the –TC modifier should be included.

RESPONSE: The Department is not sure what the commenter is referring to. The fees on the Physicians' Fee Schedule that can be billed with -TC and -26 modifiers and that also have facility fees associated with them on the ASC or HOSF fee schedules are primarily for imaging CPT codes. The services represented by these codes can be done in various practice settings including doctor's offices, ASCs, inpatient and outpatient hospital facilities. Whether the ASC or HOSF facility fee or the –TC modifier of the Physicians' Fee Schedule is billed depends on where and under what circumstances the service was performed. If the imaging code is performed as part of a surgical procedure in an ASC or HOSF, it would be appropriate to bill for the service using the ASC or HOSF facility fee code unless the imaging is included as part of the surgical procedure (see the codes on Exhibits 1 and 7).

COMMENT: One commenter requested clarification concerning the definition of "region" in how the Department implemented the statutory standard of the "reasonable and prevailing fees of 75 percent of the practitioners within a region." The commenter noted that there is a considerable difference between the fees at the same percentile on the Ingenix National Fee Analyzer and the Ingenix Customized Fee Analyzer. The Customized Fee Analyzer has fees that are much higher than those on the National Fee Analyzer and other physician fee databases, such as PMIC and Wasserman.

RESPONSE: The Department does not understand the comment as it pertains to the use of the term "region" in the statute and the Department's use of the two Medicare regions in the State, namely North and South as provided in N.J.A.C. 11:3-29.3. The Department sets the fees on the Physicians' Fee Schedule from databases of paid fees. The two Ingenix databases mentioned by the commenter as well as the other sources of fees, PMIC and Wasserman are all databases of billed fees. Finally, it is the Department's understanding that Ingenix is no longer producing fee databases.

COMMENT: One commenter likened the repeated revisions of the PIP fee schedules to "reinventing the wheel." The commenter recommended that the Department establish its own relative value scale for CPT codes and then set a dollar amount that could be multiplied by each relative value unit and adjusted by year. The commenter believed that this would diminish the need for continual revisions.

RESPONSE: The Department does not agree with the commenter. Regardless of how it is calculated, a fee schedule will require constant revision to reflect changes in CPT codes and the relative value of codes on the schedule.

COMMENT: One commenter stated that it reviewed and compared the majority of plastic surgery-related CPT codes in the proposed fee schedule for northern New Jersey, the current PIP schedule, the current Medicare fee schedule for the listed codes, and the 75th percentile for northern New Jersey according to the FAIR Health fee schedule. The commenter submitted a spreadsheet and noted that of the 225 codes evaluated by the commenter, only two are in the range of the FAIR Health schedule and four have no FAIR Health values for comparison. The rest are all close to the 130 percent of the

Medicare schedule. The commenter requests that the Department reconsider the following fees set for plastic surgery codes: 12051-13153; 15100-15121; 15732-15738; 15756-15758; and 21310-21470. The commenter expressed strong opposition to the proposed fee schedule as the plastic surgery codes are dramatically undervalued. The Department's assertion that 855 of the codes have values above the 75th percentile of the FAIR Health schedule is not borne out. Another commenter inquired why only two percent of plastic surgery codes are in the FAIR Health range while 98 percent are not.

RESPONSE: The Department does not agree with the commenters. The commenters are apparently comparing the fees in the proposed PIP fee schedule with those on the FAIR Health Consumer Cost Lookup. The FAIR Health Consumer Cost Lookup is a database of billed fees. The Department compared the fees on the PIP fee schedule with those on the allowed (paid) fee database produced by FAIR Health, which was procured by the Department. As repeatedly affirmed by the Appellate Division, the Department uses paid fee data to set the fee schedule and the amounts will not correspond to billed amounts.

COMMENT: One commenter noted that a cursory review of the data base demonstrates that common spine surgery procedures would realize a fraction of FAIR Health's estimated reimbursements. The commenter provided an attachment that demonstrated the diminishing levels of returns with the spine surgeon's work. The commenter specifically noted reimbursements for lateral fusion, laminectomy, arthrodesis/fusion, placement of intervertebral prosthetic device, laminectomy add on, cervical diskectomy, and thoracic diskectomy.

RESPONSE: The Department does not agree with the commenter. As noted above in

the Response to another Comment, the commenters are apparently comparing the fees in the proposed PIP fee schedule with those on the FAIR Health Consumer Cost Lookup. The FAIR Health Consumer Cost Lookup is a database of billed fees. The Department compared the fees on the PIP fee schedule with those on the allowed (paid) fee database produced by FAIR Health and procured by the Department. The Department appropriately uses paid fee data to set the fee schedule.

COMMENT: One commenter forwarded an EOB for CPT codes 69666 and 69667, Middle-Ear surgeries, and noted that as one of the few specialists who accepts patients injured in motor vehicle accidents, he had been paid for these codes according to the UCR standard. The fees listed in the proposed fee schedule are significantly lower than the fees in the EOB and the arbitrary reductions for multiple procedures will lower the fees for those independent procedures unreasonably and could result in even fewer, or no, surgeons who will provide this type of care to accident victims.

RESPONSE: The Department expanded the number of codes on the fee schedule to prevent routine billing of codes that are not on the schedule and to reduce the number of costly UCR determinations and arbitrations. Using the methodology affirmed by the Appellate Division, the Department reviewed the amounts paid for these codes by insurers and determined that the fee for these codes should be set at 300 percent of Medicare in accordance with the way that it has set fees for other similar services. The Department notes that the fee schedule amounts for these codes exceed the 95th percentile of allowed fees for these codes on the FAIR Health allowed (paid) fee database procured by the Department.

COMMENT: One commenter noted that a number of CPT codes on the schedule appear to have their professional (-26) and technical components (-TC) modifiers transposed: 88173; 88331; 92060; 93283; 95860; 95861; 95863; 95864; 95920; 88112; 88172; 88177; 88332; 92540; 93280; 93281; 95865; 95868; 95921; 95936; 95937 (South only); 95961; and 95962.

RESPONSE: The Department does not agree with the commenter. The codes mentioned do not have the fees for their -26 and –TC modifiers reversed.

COMMENT: One commenter noted that the following CPT codes that are on the current Physicians' Fee Schedule were omitted and suggested that they be reinserted: 11040; 11041; 27300; 27301; 27310; 27331; 27334; 27335; 27340; 27370; 27372; 27380; 27381; 27385; and 29220.

RESPONSE: The Department does not agree with the commenter. CPT codes 11040, 11041, 27300, and 29220 have been deleted from CPT and the remainder of the codes are not on the current fee schedule.

COMMENT: One commenter asked the Department to add the following codes to the fee schedule because they are routinely billed by providers: 20930; 20936; 29220; 36415; 80100; 80102; 80104; 90887; 90889; 99050; 99051; 99053; 99058; 99288; 99358; 99359; 99366; 99367; 99368; 99441; 99442; and 99443.

RESPONSE: The Department notes that it cannot add the codes to the fee schedule upon adoption as this would constitute a substantial change requiring additional notice and public comment. The Department will review the usage of the recommended codes and decide whether to include them on the schedule in future rulemaking.

COMMENT: One commenter noted that CPT 88173 is a professional component only code – "interpretation and report" – but is listed on the fee schedule with global and technical fees.

RESPONSE: The Department does not agree with the commenter. The Medicare Physicians' Fee Schedule lists the code with global, professional, and technical component fees.

COMMENT: One commenter noted that the heading of Exhibit 1, the "Physicians' & Outpatient Surgical Facility Fee Schedule," may not be entirely clear with respect to service performed within a hospital setting. The commenter recommended that the Department consider changing the heading of Exhibit 1 to "Professional Services Fee Schedule" or something similar that provides a broader connotation of the settings that are covered.

RESPONSE: The Department does not agree with the commenter. As noted above in the Response to another Comment, the Department has proposed a separate fee schedule for hospital outpatient facility fees in the notice of proposed substantial changes (new Exhibit 7) to eliminate any confusion as to what is covered by Exhibit 1. Furthermore, Exhibit 1 was renamed in the notice of proposed substantial changes to reflect that the schedule includes physicians' and ASC fees only.

COMMENT: One commenter raised a question regarding the absence on the proposed schedule of CPT codes 92700 and 92499. The commenter noted that the codes describe evaluations of organs that are particularly susceptible to damage with head trauma. The commenter noted that the equipment itself costs more than $250,000 and $25,000,

respectively, and that special facilities are required for one investigation, and doctorate level personnel are required to evaluate the data for both investigations. The commenter inquired whether the absence of the codes means that they will not be reimbursed.

RESPONSE: The Department notes that both the CPT codes mentioned by the commenter are unlisted codes, that is, the codes do not describe any specific procedure. No unlisted codes appear on the PIP Physicians Fee Schedule for that reason. N.J.A.C. 11:3-29.4(k) describes the procedures and rules pertaining to unlisted codes.

COMMENT: Two commenters noted that reimbursements rates for Computerized Dynamic Posturography (CPT code 92548) and rotary chair studies (CPT 92546) were sources of concern at the October 6 Financial Institutions and Insurance Committee hearing. In light of the compelling testimony, the commenters urged the Department to re-examine the proposed rule regarding these procedures and any others where fee schedule reimbursement has been eliminated or drastically reduced.

RESPONSE: As noted above in the Response to another Comment, the Department expanded the number of codes on the fee schedule to prevent routine billing of codes that are not on the schedule and to reduce the number of costly UCR determinations and arbitrations. Using the methodology affirmed by the Appellate Division, the Department reviewed the amounts paid for these codes by insurers and determined that the fee for these codes should be set at 130 percent of Medicare in accordance with the way that it has set fees for other similar services. The Department notes that the fee schedule amounts for these codes exceed the 95th percentile of allowed fees for these codes on the FAIR Health allowed (paid) fee database procured by the Department.

COMMENT: One commenter encouraged the Department to withdraw the proposed new fee schedule and to maintain the current level of reimbursement for CPT codes 92548 and 92546. The commenter noted that multiple peer-reviewed articles published in journals of the highest reputation have identified how frequently motor vehicle accident patients have problems of balance. The results of such investigations optimize outcomes and avoid the use of costly but ineffective investigations for these symptoms such as MRIs of the brain. The commenter noted the severe disparity between the current and proposed reimbursements and provided data on the mean, median and range of charges; the costs of the primary and supplementary test modules, and the proposed PIP reimbursement rates. To assure that the PIP insurer's multiple and serial guidelines are followed, the commenter noted that he requires additional full-time employees, healthcare benefits included.

RESPONSE: The Department does not agree with the commenter. As noted above in the Response to another Comment, the Department expanded the number of codes on the fee schedule to prevent routine billing of codes that were not on the schedule and to reduce the number of costly UCR determinations and arbitrations. The Department followed its approved methodology to establish the fees for these codes.

COMMENT: One commenter stated that the CPT codes for Manual Muscle Testing and Range of Motion measurements, 95831-4, 95851 and 95852, are bundled with the Evaluation and Management CPT codes as well as the Physical and Occupational Therapy assessment codes. The commenter asked the Department to clarify that the above codes cannot be billed in lieu of the Evaluation and Management Codes, as doing so will artificially inflate the charges.

RESPONSE: The Department does not understand the comment. None of the fees on the Physicians' Fee Schedule are bundled. N.J.A.C. 11:3-29.4(n) is the subsection of the rule that refers to Evaluation and Management services. It was not amended in the current proposal except to correct a typographical error.

COMMENT: One commenter noted that HCPCS code G0289 on the Physicians' Fee Schedule has both X and N1 payment indicators. The commenter asked if this was correct.

RESPONSE: The fee schedule is correct. G0289 is not subject to the multiple procedure reduction formula (X) and cannot be billed on its own (N1). It must be billed with 29877 or 29874.

COMMENT: One commenter urged the Department to clarify whether temporary codes ("T codes") were ever reimbursable for PIP services. The commenter noted that the American Medical Association assigns T codes for certain new surgical procedures that have not received a CPT code. Since there are no T coded procedures on the fee schedule, the commenter requested that the Department state whether payment should be made for these codes.

RESPONSE: The comment is outside the scope of the proposal. The procedure and rules governing the use of temporary codes are found at N.J.A.C. 11:3-29.4(k), which was not amended by this proposal.

COMMENT: One commenter submitted a report from a self-described expert in the fields of Medical Reimbursement Modeling and Fee Schedule Creation on the methodology and data used to create the Physicians' Fee Schedule and its reliability. The

report states that the Department based its fee schedule on the 2007 Resource Based Relative Value Scale used by Medicare in setting the 2007 Medicare Physician Fee Schedule. The report also states that the Department used allowed fee data from Ingenix to establish its fee schedule. The report goes on to compare the fees for a list of 76 CPT codes on the Physicians' Fee Schedule with the amounts from the FAIR Health Consumer lookup and concludes that the Department has failed to meet its statutory mandate.

RESPONSE: The expert who compiled the report apparently misread a quote from *In re Adoption of N.J.A.C. 11:3-29* that describes the Department's methodology for setting the Physicians' Fee Schedule that was upheld in 2009, as the methodology the Department is using for the Physicians' Fee Schedule in the current proposal. The Department did not use 2007 RBRVU or any Ingenix data to establish the fee schedule in the proposal. As described at length in the Summary to the proposal, the Department used 2011 RBRVU and Medicare data in addition to other sources of paid fee information. The fee comparison provided in the report is also misleading. It compares the PIP Physicians' Fee Schedule to the fees available on the publicly available FAIR Health Consumer Cost Lookup. The FAIR Health Consumer Cost Lookup shows billed charges while the Department's Physicians' Fee Schedule is based only on paid fee data, such as Medicare and the NY Workers' Compensation Fee Schedule and amounts paid by auto insurers. The Department purchased the FAIR Health allowed fee database to provide another data source against which to check its fee schedule and, as noted in the Summary, the fees on the PIP fee schedule were generally comparable or higher than those on the FAIR Health allowed database.

COMMENT: Several commenters expressed concern with the Department's proposal to reduce reimbursement for neuropsychological testing (CPT Code 96118). The commenters stated that: the new proposed reimbursement of neuropsychological testing is $169.32 under PIP; the fee two years ago was $208.65, which represents a reduction of $39.33 or 18.8 percent; such testing requires a special skill set; ongoing continuing education and training and the extra cost of test materials, in the thousands per update; the testing involves a complicated precertification process with insurers; the testing is often denied, triggering the need to be appealed in a limited amount of time; and neuropsychological testing is the most sensitive instrument and assessment that can determine the existence of a post concussion syndrome and cognitive deficit of the post-concussion syndrome. Missed diagnoses lead to costly and inefficient treatment. Neuropsychologists require specialized training beyond that required of a licensed psychologist and should be paid at a higher rate. Reimbursement for testing for psychologists is $166.83 and for neuropsychologists is $169.32. A neuropsychologist is only getting 1.49 percent more than a psychologist for doing psychological testing.

RESPONSE: As noted above in response to other Comments, the Department sets fees based on the CMS resource-based relative value units, which include practice costs. CMS initiated a multispecialty survey in 2007-2008 to obtain current data about the indirect costs of providing services. Prior to this survey, there was no baseline indirect practice expense data for a number of specialties, including psychology. Since 1998, psychologists' overhead expenses per hour had been linked to those reported by psychiatrists. The survey provided more accurate indirect cost data for psychology and the other specialties, which resulted in lower practice costs and therefore a lower

RBRVU. The Department had adopted the CMS RBRVU system and therefore, the fees for these services on the PIP Physicians' Fee Schedule reflect the lower amounts in accordance with the new data regarding practice costs.

COMMENT: Several commenters also expressed concern with the Department's proposal to reduce by almost 20 percent reimbursement for Health and Behavior codes. The commenters noted that the proposed reduction for these codes, used to evaluate and treat people with injuries and pain, is 14 percent or about $5.00 per 15-minute unit.

RESPONSE: As noted above in response to other Comments, the Department sets fees based on the CMS resource-based relative value units, which include practice costs. CMS initiated a multispecialty survey in 2007-2008 to obtain current data about the indirect costs of providing services. Prior to this survey, there was no baseline indirect practice expense data for a number of specialties, including psychology. Since 1998, psychologists' overhead expenses per hour had been linked to those reported by psychiatrists. The survey provided more accurate indirect cost data for psychology and the other specialties, which resulted in lower practice costs and therefore a lower RBRVU. The Department had adopted the CMS RBRVU system and therefore, the fees for these services on the PIP Physicians' Fee Schedule have appropriately been set at these lower amounts to reflect the new data regarding practice costs.

COMMENT: Several commenters expressed concern with the Department's new CPT code (96125), which is described as standardized cognitive performance testing (for example, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time

interpreting these test results and preparing the report.

The commenters stated that cognitive performance testing is done by a "qualified health care professional," and that CPT Code 96125 reimburses $142.04, which represents 83.9 percent of what CPT Code 96118 would reimburse. The proposed PIP fee schedule is reimbursing the "qualified health care professional" 83.9 percent of CPT Code 96118, a service provided by a licensed psychologist.

The commenters also stated that it is unclear what "qualified" means and questioned whether it means that a license is required; a license in a related field is required; an educational degree is required; and/or that neuropsychological testing can only be done by a licensed psychologist competent in neuropsychology.

RESPONSE: The Department notes first that the question as to what "qualified" means should be addressed to the American Medical Association (AMA) that developed the CPT code. The Department simply included a code developed by the AMA. However, the AMA provided the following definition of "Qualified Health Professional" in a notice of corrections to the 2012 CPT Manual at

http://www.ama-assn.org/resources/doc/cpt/cpt-2011-corrections.pdf:

"A 'physician or other qualified healthcare professional' is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from 'clinical staff'. A clinical staff member is a person who works under the supervision of a physician or other qualified healthcare professional and who is allowed by law,

regulation and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service. Other policies may also affect who may report specific services."

In addition, transmissions from Medicare indicate that 96125 can be billed by Occupational Therapists, Physical Therapists and Speech Language Pathologists. (http://downloads.cms.gov/medicare-coverage-database/lcd_attachments/31990_5/L31990_PSYCH017_CBG_060112.pdf), which is why the reimbursement level is lower than services by a physician or psychologist. The CPT manual also states that psychological and neuropsychological testing by a physician or psychologist should be billed using CPT 96101-96103 and 96118-96120.

COMMENT: Several commenters also noted that the general psychological testing code (96101) is also being substantially reduced by 18 percent. The commenters stated that these issues are important since they affect both the quality of services that New Jersey citizens receive, and also access to quality care. The commenters stated that as reimbursement rates go down, fewer and fewer qualified professionals are willing to provide the service, thus limiting citizens' ability to find the care that they need.

RESPONSE: As noted above in response to other Comments, the Department sets fees based on the CMS resource-based relative value units, which include practice costs. CMS initiated a multispecialty survey in 2007-2008 to obtain current data about the indirect costs of providing services. Prior to this survey, there was no baseline indirect practice expense data for a number of specialties, including psychology. Since 1998, psychologists' overhead expenses per hour had been linked to those reported by

psychiatrists. The survey provided more accurate indirect cost data for psychology and the other specialties, which resulted in lower practice costs and therefore a lower RBRVU. The Department had adopted the CMS RBRVU system and therefore, the fees for these services on the PIP Physicians' Fee Schedule are lower due to the reevaluation of practice costs by CMS.

COMMENT: One commenter stated that neuropsychologists require a significant amount of specialty education, training, clinical experience, and competence to be able to conduct the comprehensive and objective testing, and later rehabilitation services required to address the serious needs of the head injured population. The commenter contends that their specialty and expert abilities have been underpaid for decades. The commenter believes that further reductions are not only inappropriate and unjustified, but will lead to a further reduction of the already extraordinarily limited pool of appropriate providers willing and available to render the testing and treatment necessary to return brain injured persons back to their daily routines. Additionally, the commenter stated that the vast majority of Neuropsychological Testing (2011 CPT code 96118) and Cognitive Rehabilitation Treatment (2011 CPT code 97532) rendered in New Jersey for non-motor vehicle accident brain injured patients is done on an outpatient private practice basis at fees ranging from two to four times the new Auto PIP Fee reimbursement rates currently in effect. Any action to reduce the already diminished New Jersey Auto PIP Fee Schedule for this specialty will additionally harm brain injured victims through a reduction in available providers, and force injured patients and their families to utilize scarce out-of-pocket expenditures, especially in the middle of a serious recession where so many families are already suffering.

RESPONSE: As noted above in response to other Comments, the Department sets fees based on the CMS resource-based relative value units, which include practice costs. CMS initiated a multispecialty survey in 2007-2008 to obtain current data about the indirect costs of providing services. Prior to this survey, there was no baseline indirect practice expense data for a number of specialties, including psychology. Since 1998, psychologists' overhead expenses per hour had been linked to those reported by psychiatrists. The survey provided more accurate indirect cost data for psychology and the other specialties, which resulted in lower practice costs and therefore a lower RBRVU. The Department had adopted the CMS RBRVU system and therefore, the fees for these services on the PIP Physicians' Fee Schedule are lower.

N.J.A.C. 11:3-29 Appendix, Exhibit 4

COMMENT: One commenter observed that in many instances bills are received from two distinct entities for a single transport – one for the ambulance and the other for paramedic services often using the same HCPCS code. The commenter asked the Department to comment on how it should reimburse for these duplicate billings for transport and the services of a paramedic or nurse who travels in the ambulance during transport.

Another commenter noted that when the fee schedules were made available to interested parties as part of the Executive Order No. 2 process, HCPCS code A0432 was included but it was not in the proposal. The commenter stated that A0432 is defined as, "Paramedic intercept (pi), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers." The

commenter suggested that this code could be used to address the issue of paramedics billing an unlisted ambulance code when they respond in addition to the ambulance transport provider who bills for ALS or BLS services. The commenter noted that paramedics are not permitted to transport patients, with the result that insurers are billed for duplicate services. The commenter also asked the Department to add the following codes to the ambulance fee schedule: A0080; A0110; A0130; and A0424.

RESPONSE: Upon receipt of the comment concerning the separate billing of paramedic and ambulance services, the Department has determined that this is a complex issue that has not been previously brought to the Department's attention. The arrangements for ambulance and paramedic services vary by community and sometimes the ambulance and the paramedic services are provided by different entities and billed separately. Medicare rules do not permit separate billings for these services. The Department notes, however, that nothing in the adopted rules has changed except the fees for ambulance services. The same HCPCS codes are on the new fee schedule as were on the prior fee schedule. Therefore, the issue of separate billing for ambulance and paramedic services was not created by the adopted new rules. The Department will investigate and may address the issue in future rulemaking.

The commenter is correct that the Department included HCPCS code A0432 in the draft of the rule presented at the Executive Order No. 2 meeting. The Department received a comment after that meeting that it was not appropriate to include A0432 on the schedule since New Jersey does not include any rural areas as defined by CMS. Therefore, it was removed from the final proposal. The Department does not agree with the commenter that this code would address the issue of separate paramedic reimbursement. As noted above,

the Department will study the issue of separate reimbursement for paramedic services and may address the issue in future rulemaking. Concerning the other codes that the commenter suggested be added to the fee schedule, the Department notes that they are for various types of non-emergency transportation and for an extra ambulance attendant. The Department invites the commenter to submit data showing why these codes need to be added to the fee schedule including frequency of billing. The Department will review the information and may include the codes in future rulemaking.

N.J.A.C. 11:3-29 Appendix, Exhibit 5

COMMENT: One commenter stated that the Department has specifically excluded TENS and EMS units from Medicare reimbursement rates because these devices can be purchased for $200.00 on the Internet. This argument fails to consider the significant costs and overhead incurred by a DME supplier in obtaining the equipment and supplies, which raises the provider's cost of providing a unit to an insured far over $200.00. Additionally, just because a piece of DME equipment or medicine can be found on the Internet does not make it legal, safe, or valid, and the purchaser is not getting a physician’s instructions, follow-up, etc., services for which a physician is not allowed to bill separately. The commenter thought that it is odd that the Department would set other durable goods at 100 percent of the Medicare rates, except for TENS or EMS units. In addition, how can the purchase price of a TENS or EMS unit include all supplies for life? Even the Internet offer does not include all supplies for life. The Department’s summary concedes that EMS units are currently reimbursable per Medicare for a monthly rental of $93.99, capped at a maximum of 10 months, or $939.90 total. According to the commenter, the Department proposes that the one-month rental be reimbursed at $20.0,

and that a purchase of the device be reimbursed at a maximum of $200.00, and also suggests that the cost of the supplies necessary to operate the EMS unit (which traditionally have been billed separately) not be included within the $200.00. Additionally, the commenter asserted that the Department also notes that a TENS unit is currently reimbursable per Medicare at $389.00, and proposes that the purchase of a four-lead TENS unit should now be reimbursed at $100.00. If the values for TENS units and EMS units are reduced to $200.00, it would be mathematically impossible to provide these products because overhead and deductibles would make these products unavailable to the injured people that need these devices. Many injured people have drug allergies or other issues that preclude them from taking medications. TENS and EMS units do not have drug interactions and can provide immediate relief. Many injured people do not have health insurance and rely on their automobile insurance for their injuries. Another commenter noted that this schedule is arbitrary and capricious, especially when considering that other fees that were based on Medicare were set at 130 percent to 300 percent. Another commenter asked for clarification on whether the supplies for TENS and EMS units can ever be billed since the proposal does not include a code for such supplies.

RESPONSE: The Department agrees with the commenters in part. The issue of billing for supplies for purchases of TENS and EMS units is addressed above in the Responses to Comments on the changes in the notice of substantial changes upon adoption.

The Department addressed the issue of reimbursement for TENS and EMS units upon receipt of information from insurers that some providers provide these devices to patients regardless of the diagnosis and that every single patient rents the device for the maximum

rental period. The cost of a 10-month rental in Northern New Jersey, $939.90, is not such a large amount that it would make an arbitration or fraud investigation worthwhile but the individual charges add up. The Department notes that in 1993, Medicare issued a Local Coverage Determination (LCD) for Transcutaneous Electrical Nerve Stimulators (TENS) (L11506) that imposed the following limitations on the use of TENS units, which substantially limited overuse:

A transcutaneous electrical nerve stimulator (TENS) is covered for the treatment of patients with chronic, intractable pain or acute post-operative pain who meet the coverage rules listed below.

When a TENS unit is used for acute post-operative pain, the medical necessity is usually limited to 30 days from the day of surgery. Payment for more than one month is determined by individual consideration based upon supportive documentation provided by the attending physician. Payment will be made only as a rental. A TENS unit will be denied as not reasonable and necessary for acute pain (less than three months duration) other than post-operative pain.

For chronic pain, the medical record must document the location of the pain, the duration of time the patient has had the pain, and the presumed etiology of the pain. The pain must have been present for at least three months. Other appropriate treatment modalities must have been tried and failed, and the medical record must document what treatment modalities have been used. The presumed etiology of the pain must be a type that is accepted as responding to TENS therapy. Examples of conditions for which a TENS unit are not considered to be reasonable and necessary are (not all-inclusive): headache, visceral abdominal pain, pelvic pain, and temporomandibular joint (TMJ) pain.

When used for the treatment of chronic, intractable pain, the TENS unit must be used by the patient on a trial basis for a minimum of one month (30 days), but not to exceed two months. The trial period will be paid as a rental. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating the pain. For coverage of a purchase, the physician must determine that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. The physician's records must document a reevaluation of the patient at the end of the trial period, must indicate how often the patient used the TENS unit, the typical duration of use each time, and the results.

The Department did not impose these limitations except as part of the precertification process. This overutilization combined with the widespread availability of these devices at prices so much lower than those on the Medicare fee schedule made the Department decide to reduce the fees for these devices to the more consistent and reasonable prices available in the marketplace. The Department believes that this reduction in reimbursement comports with its duty in N.J.S.A. 39:6A-4.6 to promulgate fee schedules incorporating the reasonable and prevailing fees of 75 percent of practitioners on a regional basis. The Department does not agree with the commenters that suppliers of these devices have to pay higher fees for the devices. Many of the companies that offer the devices on the Internet are the same companies as the suppliers to medical providers.

On June 8, 2012, subsequent to the proposal of the rule and the notice of proposed substantial changes upon adoption, CMS issued a bulletin announcing that effective immediately, it was no longer reimbursing for TENS units to treat chronic lower back pain (CLBP) unless the pain is the result of a clearly recognized disease entity such as

metastatic cancer or multiple sclerosis. The decision was based on a 2010 study by the Technology Assessment Subcommittee of the American Academy of Neurology, which determined that use of TENS unit were ineffective for the treatment of CLBP. The Department will review the determination by CMS and may further address the compensation for TENS units in future rulemaking.

COMMENT: The values listed for services rendered and durable medical equipment (DME) is greatly inaccurate in the proposed PIP Medical Fee Schedule. If a value for a product is listed as $1,000, the real value is $700.00 because providers fall into two categories, in network and out of network. In-network providers must agree to a 30 percent reduction of the value listed in the PIP Fee Schedule, and out-of-network providers are assessed a 30 percent out-of-network penalty. After copayments are assessed on the $1,000 charged, the actual maximum value is $700.00. The $700.00 is further reduced by the 20 percent copayment and $250.00 deductible, and another 30 percent precertification penalty can be added if the provider makes a mistake by faxing or mailing to the wrong insurance company. This additional 30 percent reduction is not uncommon because many people give the physicians the insurance information of the person whose vehicle they were in at the time of the accident, not the insurance information of their resident relative, etc. This is a huge penalty for an honest mistake.

RESPONSE: The Department does not agree with the commenter that the fees on the Durable Medical Equipment fee schedule are "inaccurate." There are many reasons why a provider might not receive the amount on the fee schedule. These include that the provider's UCR is less than the fee schedule amount, participation in networks and application of the out-of-network penalty. The purpose of networks is to use economies

of scale to give insureds more benefits for their claim dollar. As for the policy deductible and co-payment, the provider is supposed to collect those from the insured. The Department does not understand how the 30 percent penalty for failure to precertify would apply unless the provider did not wait for the insurer to respond before providing the item of DME to the insured.

N.J.A.C. 11:3-29 Appendix, Exhibit 6 – Codes subject to the daily maximum

COMMENT: One commenter objected to the inclusion of the strapping codes in the daily maximum. The commenter believed that including these codes was unnecessary since the Department had prohibited billing kinesiotaping using the strapping codes.

RESPONSE: The Department does not agree with the commenter. The strapping codes are included in the daily maximum because they are commonly billed together with other physical medicine procedures. While it is true that kinesiotaping can no longer be billed under the strapping codes, the Department is concerned that this practice will continue.

COMMENT: One commenter requested that CPT 97139 be added to the codes in Exhibit 6. Another commenter recommended that the Department include CPT 97799 and 99199 to the daily maximum to prevent providers from evading the daily maximum by using unlisted codes.

RESPONSE: The Department notes that CPT 97139 was added to Exhibit 6, Codes Subject to the Daily Maximum, in this rulemaking. CPT 97799 and 99199 are also codes for unspecified services. The Department believes that the restrictions on billing unlisted codes in N.J.A.C. 11:3-29.4(k) should prevent these codes from being used to evade the daily maximum. However, if the Department receives evidence that these unlisted codes

are being used to evade the daily maximum, the Department will add them to the daily maximum in future rulemaking.

COMMENT: One commenter claimed that the addition of new codes to the daily maximum is arbitrary and capricious, and inquired what information and what insurers provided the information that the codes have dramatically increased? Was this confirmed by any independent source or a fee database?

RESPONSE: The Department solicited and received information from auto insurers on what codes have increased in frequency, indicating that some providers were using them to evade the daily maximum. As these practices are limited to PIP, there is no outside source that can confirm them.

COMMENT: Several commenters inquired how can a default code or an unspecified code be included in the daily maximum, for example, 97039 and 97139, since it would be impossible beforehand to know that these codes are commonly provided together.

RESPONSE: Information from insurers indicated that these codes are frequently billed for services that are similar to those on the daily maximum in an effort to evade it. The Department does not believe that there are any unlisted modalities or therapeutic procedures that should be outside the daily maximum.

COMMENT: Several commenters objected to the reduction in the reimbursement for kinesiotaping to a proposed fee schedule of 27 cents. The commenters noted that this commonly used procedure by musculo-skeletal practitioners throughout the Olympic and professional sports world, which involves a doctor's diagnosis, materials, and application of the materials, will now be reimbursed at 27 cents. One commenter urged that the

Department specifically state that kinesiotaping is not reimbursable.

RESPONSE: The Department does not agree with the commenters. The American Medical Association has not seen fit to create a CPT code for kinesiotaping, which is a prerequisite for its separate reimbursement. The Department acknowledges that it may be a useful technique but its use to treat injuries from motor vehicle accidents is included in other therapeutic procedures. The only separately reimbursable item relating to kinesiotaping is the tape.

COMMENT: One commenter requested that the CPT codes for osteopathic manipulative treatment be excluded from the daily maximum. The commenter stated that doctors of osteopathy do not typically set a treatment plan, typically render a significantly lower number of manipulative services per patient as part of the patient's management, are fully licensed for the unrestricted practice of medicine and surgery as well as osteopathic manipulative treatment, and are held to a higher standard of care than chiropractors and physical therapists because of their broad scope of training and licensure. It is inappropriate to include osteopathic manipulative treatment (OMT) in the same category of service or subject OMT to the same benefit limitations as those for chiropractic or physical therapy services. The CPT Editorial Panel created separate CPTs for these services.

RESPONSE: The Department does not agree with the commenter. The osteopathic manipulation codes were added to Appendix, Exhibit 7 in the last revision to the fee schedule, which was upheld by the Appellate Division in *In re Adoption of N.J.A.C. 11:3-29*. 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 stated that in proposed new N.J.A.C. 11:3-29 Appendix, Exhibit 6, Codes Subject to the Daily Maximum, acupuncture is bundled into the $105.00 daily maximum. The commenter noted that some acupuncture is performed by medical doctors and doctors of osteopathy and should not be bundled in with other therapies procedures, thereby penalizing the physician performing the stand-alone treatment.

RESPONSE: The Department does not agree with the commenter. Inclusion of the acupuncture codes in the daily maximum does not prevent any provider qualified to perform the treatment from doing so on a stand-alone basis. It only means that the maximum daily reimbursement for the codes listed in Exhibit 6 is $105.00.

COMMENT: Two commenters expressed concern about the effect that the Department's proposed new PIP rules and amendments will have on the practice of acupuncture. The commenters stated that it is patently unfair to include acupuncture in the daily cap of services. The commenters contend that the acupuncturist spends an enormous amount of time with each patient and, unlike many physicians, the acupuncturist actually remains with the patient during a substantial portion of the administration of the relevant procedures, often not leaving the room. The commenters further contended that by

limiting such an important service by making it subject to the daily cap, insurance companies would have an additional excuse to simply deny coverage to patients who desperately need their services.

The commenters also stated that the proposed amendments would greatly hamper their business and the business of other acupuncturists. The commenters asserted that many of their patient referrals really need immediate treatment on the same day they visit a physician, a physical therapist, or a chiropractor. By subjecting acupuncture to the cap, they would be unable to treat anyone who visits a physical therapist, chiropractor, or even a dentist on the same day. The commenters stated it would be a tremendous inconvenience to New Jersey employees for them to miss an additional day of work because the amendments prevented them from seeing their acupuncturist on the same day they see another provider.

Additionally, the commenters stated that the proposed amendments would result in extensive delays or denials of treatment to patients who require their care. The commenters requested that the Department not adopt the proposed rules and that the Department consider other alternatives such as amendments to the applicable fee schedules. Another commenter noted that the Department's explanation for including acupuncture in the daily cap is that acupuncturists are now performing and billing other physical medicine rehabilitation codes in addition to the acupuncture codes and that these services are similar to those performed by chiropractors and osteopathic physicians. The commenter stated that codes when performed by an osteopathic physician are not included in the daily cap, and the standard acupuncture codes are included in the daily cap, not just those codes that are akin to chiropractic treatment.

RESPONSE: The Department does not agree with the commenters. N.J.S.A. 39:6A-4.6.b states that the Commissioner may establish the use of a single fee, rather than an unbundled fee, for a group of services if those services are commonly provided together. Based on information received from insurers, an increasing number of acupuncture providers are associated with chiropractic clinics and physical therapists and insureds get both treatments on the same dates.

The Department does not believe that inclusion of acupuncture services in the daily cap will cause extensive delays or denials of acupuncture services to patients. The Department also does not agree with the commenter who stated that osteopathic manipulation is not included in the daily maximum and that acupuncture treatments ought to be treated similarly. The exemption from the daily maximum for osteopathic manipulation codes was removed from the schedule when the rule was amended in 2008.

COMMENT: One commenter stated that upon examining the Acupuncture CPT codes 97810, 97811, 97813, and 97814, the Department's proposed amendments not only decrease the fees, but decrease them drastically. The commenter contends that this will more than likely result in less acupuncture practitioners being willing to participate in the care of those injured in motor vehicle accidents. The commenter stated that acupuncture significantly helps people who are recovering from such injuries, noting that they have seen first hand the difference it has made in pain levels, less need for pain medications, increases in range of motion, less days lost from work and improvements in average daily life activities.

The commenter suggested that the Department take a closer look at the fee

schedule; specifically the codes involved in acupuncture treatment and reconsider its proposal to lower those fees so dramatically.

RESPONSE: The Department notes that acupuncture is not reimbursable under Medicare and CMS and, therefore, those entities have not determined any resource-based relative values for these services. To find another source of paid fee data to update the fee schedules for acupuncture codes, the Department looked to the FAIR Health allowed (paid) database of fees, which the Department had procured. The fees were set at the 95th or highest percentile of allowed fees in this database for representative zip codes in North and South Jersey. The fees derived from the FAIR Health allowed fee database were lower than the fees on the current fee schedule. However, the Department believes that it has an obligation to set fees at the most current amounts. The 95th percentile means that 95 percent of providers are receiving this amount or less for theses codes from health payors.

COMMENT: One commenter stated four reasons why they believe that the Department should refrain from adding four acupuncture codes to the Schedule of Codes that are subject to the daily maximum.

Point I: There is no evidence that doing so will advance DOBI's stated goal of reducing the number of providers who wrongfully attempt to evade the fee schedule.

Part of the Department's stated reason for expanding the codes subject to the daily maximum cap to include four new acupuncture codes is to reduce the number of providers who wrongfully attempt to evade the fee schedule by using improper codes instead of the actual codes that apply to the treatment that those providers are rendering

to their patients. The commenter stated that there is no evidence that the few physicians who wrongfully miscode their procedures in an effort to evade the fee schedule will be deterred by an expansion of the coding system. The commenter argued that the acupuncture codes the Department has proposed to include on the list of codes subject to the daily maximum encompass crucial procedures that are unique and distinct to the field of acupuncture. The commenter believes that rather than making it more difficult for trained and experienced acupuncturists to receive proper compensation for legitimate treatment provided to patients, the Department instead should work towards increasing the penalties on those few physicians who misrepresent the scope of their treatment to evade the fee schedule. The commenter does not believe that there is a rational basis between the Department's inclusion of the acupuncture codes subject to the daily maximum and the Department's stated goal of reducing fraudulent coding by treatment providers.

Point II: The procedures encompassed by the acupuncture codes at issue are not similar to other types of treatment provided by chiropractors and osteopathic physicians.

The commenter disagrees with the Department that acupuncture codes should be subject to the daily maximum cap because the procedures encompassed by those codes as the Notice of Proposal stated, are "similar to [treatment provided by] other types of providers such as chiropractors and osteopathic physicians." The commenter stated the Department's position seems to be predicated upon a misunderstanding of the types of services referenced in the acupuncture codes at issue.

The commenter states that acupuncture has become a recognized field of practice

in the United States, with internationally recognized medical institutions including Memorial Sloan-Kettering in New York and the University of California - San Francisco Medical Center implementing acupuncture departments. The procedures at issue involve the insertion of acupuncture needles (both with and without electric current) at specific identified sites throughout the body. The insertion stimulates the tissue directly under the skin. In turn, such stimulation activates the body's healing properties, assisting in the reduction of swelling and pain to the patient. Acupuncture has become a standard modality used in treatment of patients with pain and injuries to the bone, tissue and muscle.

According to the commenter, such procedures are separate and distinct from the types of treatment modalities typically implemented by chiropractors and osteopathic physicians, who rely upon direct manipulation of the spine and/or joints at issue in an effort to correct the misaligned area.

The commenter stated that acupuncture is fundamentally different from chiropractic treatment and osteopathic medicine. Lumping acupuncture into the same categories as chiropractic treatment and osteopathic medicine is arbitrary and ignores the nature and purpose of the procedures at issue.

Point III: Including the subject acupuncture codes on the list of codes subject to the daily maximum will harm patient care and increase costs and litigation.

The commenter further stated that including the subject acupuncture codes on the list of codes subject to the daily maximum will unfairly dissuade individuals from seeking acupuncture treatment and will lead to an increase in costs and litigation. The

commenter contends that many studies have shown that acupuncture offers an effective, low-cost, and drug-free treatment option to patients. The commenter believes that patients should not be forced to choose between acupuncture and other different treatment modalities simply because those different treatment modalities are scheduled to occur on the same day, which the commenter believes is precisely what will happen under the Department's proposed amendments. Patients will be forced to choose between paying out of pocket for acupuncture, foregoing a separate and distinct treatment modality that could help relieve their pain in a low-cost manner, or instituting litigation to secure reimbursement for the acupuncture treatments. The commenter stated that such forced choices are unnecessary and undermine the Department's stated position of reducing costs and litigation.

Point IV: The adoption of the subject codes will harm the acupuncture industry.

Finally, the commenter stated that including the subject acupuncture codes on the list of codes subject to the daily maximum will harm the acupuncture industry. The commenter noted that in New Jersey there are approximately 600 licensed acupuncture practitioners, the majority of whom own their own small business or are employed by a small business. The commenter believes that subjecting the specified acupuncture codes, which encompass the central aspects of acupuncture treatment, to the daily maximum will undermine the ability of these small businesses to receive reimbursement for necessary and proper procedures performed in the course of their business. Particularly in the current economy, it is unconscionable to pressure such small businesses and to pit them against other treatment providers.

RESPONSE: As noted above in the Response to another Comment, the Department does not agree with the commenters. N.J.S.A. 39:6A-4.6.b states that the Commissioner may establish the use of a single fee, rather than an unbundled fee, for a group of services if those services are commonly provided together. Based on information received from insurers, an increasing number of acupuncture providers are associated with chiropractic clinics and physical therapists and insureds get both treatments on the same dates. The Department does not believe that the efficacy of acupuncture treatment can be determined if it is provided at the same time as other treatment. Therefore, the Department does not believe that inclusion of acupuncture services in the daily cap will cause extensive delays or denials of acupuncture services to patients.

Not in proposal

COMMENT: One commenter stated that the Department has not addressed excessive hospital billing in the proposal. The commenter cited a report published in 2009 by the New Jersey Health Care Quality Institute, which found that New Jersey leads the nation in hospital prices and that charges by New Jersey acute care hospitals are four times higher than the actual cost of treating a patient. The commenter noted that hospitals typically negotiate their fees to 25 to 30 percent of billed charges for health insurers and PIP insurers. The commenter believed that requiring auto insurers to pay billed charges for trauma services in hospitals put upward pressure on rates and utilized a disproportionate share of the insured's PIP dollar, thus limiting the rehabilitation opportunities for those severely injured in motor vehicle accidents. The commenter observed that there were resources available for the Department to establish a reasonable and prevailing fee schedule for hospital in-patient services and asked if the Department

planed to address this concern in future rulemaking.

RESPONSE: The comment is outside the scope of the proposal. The Department is not considering proposing a hospital fee schedule at this time.

COMMENT: One commenter stated that PIP insurers may be requiring physicians to pay for remittance advice documents and other records in its possession. The commenter strongly objects to this practice and asks the Department to include a provision that would prohibit PIP insurers from charging providers for documents that are necessary to process PIP claims or appeals, or in the alternative, that the Department support cessation of this practice.

RESPONSE: The Department does not know what the commenter is referring to. The commenter is requested to submit additional information to the Department concerning this issue.

COMMENT: One commenter requested that the Department change the rules concerning the ability of doctors and lawyers to receive information on motor vehicle accident reports. The commenter stated that he has had insureds arrive with multiple solicitations from lawyers promising cash settlements if the injured person goes to the lawyer's doctor. The commenter requested that such practices be made illegal instead of the making it more difficult for providers to help people in pain.

RESPONSE: The Department agrees with the commenter that many insureds are solicited by lawyers. However, the Department does not regulate who can access motor vehicle accident reports and therefore this comment is outside the scope of the proposal.

3. Comments Received upon Publication of Notice of Proposed Substantial Changes upon Adoption to Proposed New Rule

The Department received comments from the following parties on the Notice of Proposed Substantial Changes:

Steven Brownstein, MD, Spinal Kinetics
Cora M. Chuffo
Michael Cikacz, Injured Workers' Pharmacy
James Z. Cinberg, MD
Donald Cioffi, DC
Laurie Clark, NJ Association of Osteopathic Physicians and Surgeons
Robin Delgado, Auto Injury Solutions
Lawrence Downs, NJ Hospital Association
John E. Fanburg, Esq., New Jersey Association of Ambulatory Surgical Centers
Joseph C. Grassi, NJ Association for Justice
Richard R. Guma, DC Premier Prizm Solutions
Sean T. Hagan, Esq.
Jeanne M. Heisler, Independent Insurance Agents of NJ
James E. Heyl, Esq.
Micaela Isler, Property Casualty Insurers of America
Sheila Kenny, MetLife Auto and Home
Chuck Leitgeb, Insurance Council of New Jersey
Mitchell Livingston, NJM Insurance Group
Jonathan Lustgarden, MD, NJ Neurosurgical Society
Edward Magaziner, MD, NJ Society of Interventional Pain Physicians
Mark E. Manigan, Esq., New Jersey Orthopaedic Society
Josephine S. Minardo, PsyD, NJ Psychological Association
Al Ross Pearlson, Esq., NJ Coalition for Quality Health Care
Bill F. Puglisi, DC, Spinal Kinetics
Catherine Purnell, RN, NJ Health Care Quality Institute
Karen Ritchie, Mitchell International
John D. Rogers, Horizon Blue Cross and Blue Shield of NJ
Shari A. Rivkind, Esq., Rivkind Law Firm
Elizabeth A. Ryan, New Jersey Hospital Association
Mary E. Ryan, Medtronic Corporation
Jane Selzer, NJ Psychological Association
Jeffrey Shanton, Journal Square Surgery Center
Steven M. Shiner, American Commerce Insurance Company
Brianna Sivera, CPC, Procura Management
Charles Vogel, State Farm Insurance Companies
Scott Woska, MD NJ Society of Interventional Pain Physicians

Melissa Gencarelli
R. Fishet
Thomas Compeau, Monmouth Total Health Care
Janet Crain
Ira Klemins
Dariusz Nasiek (Englewood, NJ)
Corey Evans
John Ediger, Conover, Tuttle & Pace Advertising
Peter Roberts (Caldwell, NJ)
Laura Newman
Philip Cantore
Magdalene Spak
Nova Rogers
David DePaolis
Douglas Goldsmith
Thomas Walaszcyk
Peter Roberts (Edison, NJ)
Michaelene Callahan
Robert Kramberg
Danielle Dronet
Daniel Tamburro
Steve Solokoff
Candace Thomas
Dennis Long
Alizabeth Acevedo
Christopher Oliveira
Frank Gasparrovic
Veera Gupta
James Doherty
Bill Lehr
Kaizanu Liu
Peter Wohl
Yvonna Martin
Anton Stranov
Sandra Baliya
Neil Schneider (Voorhees, NJ)
Svetlana Martin
Gizele Velez-Thomas
William Thomas
Julio Parades
Keri Fessler
Raffi Khorozian
Kiley Escamilla
Sarah Escamilla
Xerxes Oshidar
Ethel Massa

Neil J. Schneider (Gibbsboro, NJ)
Jennifer Richardson
Pat Robinson
Ana Santacruz, NJ Institute of Radiology
Linda Rabeiro
Alan Pine
Vincent DelGoozzo
Michael Dobrow
Joseph Maggiano
Paul Martin
Andrew Judd
David Srulevich
Laura Gilfone
Kelly Walker, Hamon Custodis, Inc.
Frank Fredericks
Antionette Fredericks
Evelyn Merced
Sharon Cadmus
Susan Strauss
Reihold Strauss
Ronald Strauss
Lauren Felo
Debra Gaul
Lauren Wohlstetter
Donna Master
Jaime Martinez
Patricia Jacopino
Debra Merendino
Dariusz Nasiek (Wayne, NJ)
Vavrinec Fecko
Regina Alusikova
Leah Thompson, Kimba Medical Supply
Michael Golowski, Therapeutic Devices, Inc.
Sonya Valentin
Kathy Saunders
Ryan Rusinski

COMMENT: One commenter stated that it continued to fully support the Department's efforts to revise the regulatory PIP framework to contain costs and increase the value of the PIP benefit to injured persons.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter expressed support for the amendments in the notice of proposed substantial changes and stated that they incorporated many of the changes recommended in comments to the original proposal. The commenter stated that issues concerning the use of surgical codes by non-surgical specialists is still of concern. The commenter noted that neurosurgeons are alarmed by the many patients who need surgical care but who have exhausted their coverage on treatments, which failed to address their underlying injury. The commenter hoped that the Department could use his Society's expertise to address fraud, overutilization, and mis-utilization of treatment and process errors in the reimbursement system for auto accident victims.

RESPONSE: The Department appreciates the support and looks forward to working with the commenter's Society to addressing the other issues raised by the commenter, which are outside the scope of the proposal.

COMMENT: Several commenters noted that the original proposal offered an opportunity to control loss costs for PIP and would reduce, or at least control, the long-term premium for the PIP coverage. The commenters were concerned that the changes in the notice of proposed substantial changes on adoption will not benefit consumers as much since many of the loss control provisions were removed or weakened. One commenter hoped that the Department will adopt regulations that truly control costs in the future. Another commenter urged the Department to reconsider some of the changes made in the notice of proposed substantial changes on adoption that it believes will increase costs in the PIP system.

RESPONSE: The Department does not agree with the commenters that the changes in the notice of proposed substantial changes will not benefit consumers. The commenters

have not addressed any specific changes so the Department is unable to provide a more particularized response.

COMMENT: One commenter thanked the Department for considering its comments to the original proposal, several of which were incorporated into the notice of proposed substantial changes on adoption, including the removal of Workers' Compensation Managed Care Organizations from N.J.A.C. 11:3-4.4(d) and the removal of the 117 CPT spinal and neurosurgery codes from the Physician's Fee Schedule. The commenter believes that there is a shortage of these specialists to treat the PIP population. The commenter noted that in its comments to the original proposal, it had requested that the Department re-evaluate whether the physician fees for specializing in pain management were adequate. The commenter was disappointed that the Department did not increase or remove fees from the schedule pending further consideration. The commenter remains concerned that the fees for pain management procedures, in particular, are undervalued. Further, the commenter cited a study that noted that the economic benefits of effectively treating patients included: reduced pain and suffering; increased worker productivity; and reduced future healthcare costs. The commenter also stated its opinion that the Department should not be limited by the Medicare Fee Schedule and should, at a minimum, consider the fees in the FAIR Health database. The commenter also reiterated its comment to the original proposal stating its position that the arbitration process is an essential tool to ensure that appropriate treatment is available to PIP patients. The commenter renewed its request that the Department monitor the arbitration process and make representative arbitration decisions available on its website. The commenter believes that such transparency will result in less arbitration and more certainty for

providers.

RESPONSE: The Department does not agree with the commenter's contention that the fees for pain management are inadequate. As described more fully above in the Response to a Comment made by this commenter to the original proposal, it was Medicare, not the Department, that reduced the fees for pain management services based upon a reevaluation of the practice costs for such services. The Department also does not agree that there is a shortage of pain management providers for PIP patients. Pain management procedures are among the most commonly performed treatments for PIP patients. The Department also does not agree that the Department has only considered the Medicare fee schedule in developing the fee schedule. As discussed more fully above in the Responses to Comments to the original proposal, the Department followed the same procedure as was upheld by the Appellate Division in *In re adoption of N.J.A.C. 11:3-29*, which included review and analysis of multiple data sources including auto insurer paid fees and FAIR Health allowed fee data.

COMMENT: One commenter requested that the Department delay adoption of the proposal until everything has been released. The commenter noted that the Pain Protocols still have not been shared and stated that they will be an integral part of the entire process.

RESPONSE: The Department does not agree with the commenter that the adoption should be delayed until the release of the Pain Management treatment protocols currently being developed. The Department strongly believes that it is imperative to adopt these reforms as soon as possible to achieve cost-containment, provide maximization of PIP benefits for insureds, increase the cost-certainty, efficiency, and timeliness of the PIP

process for insureds, insurers, and providers, and to combat fraudulent practices in PIP.

COMMENT: One commenter expressed a concern that the Department's focus was misplaced. The commenter believed that the Department is focusing on medical providers as if they are causing all the problems with no-fault benefits. The commenter believes that the Department should focus on the abuse of carriers and their vendors who harm patients. The commenter asserted that insurance companies and their vendors routinely deny treatment without performing the proper reviews or simply delay the claim by asking for records that have already been provided. The commenter believes that no-fault benefits were enacted by the Legislature as a social agenda to protect the insured and were not intended to be a profit-making coverage for insurers. The commenter believes that the insurers are concealing the fact that they are making record profits on automobile insurance in New Jersey as evidenced by the fact that all the major insurance companies write policies in New Jersey and aggressively advertise.

RESPONSE: The Department does not agree with the commenter. The adopted new rules and amendments do not focus exclusively on providers. The vendor registration provision and internal appeal process are directed at insurers. The Department monitors insurer conduct through complaints and Market Conduct Examinations. Most insurance is sold by insurers that are for-profit, publicly-owned companies. These companies and their shareholders expect to make a return on their investment. The auto insurance market in New Jersey is vigorous and competitive benefits policyholders because insurers are competing for the best business. This competition reduces insurer profit because companies with higher rates lose business. According to the latest NAIC profitability report (issued in 2011), the New Jersey aggregate "Profit on Insurance Transaction" as a

percent of Direct Earned Premium for Private Passenger Auto (PPA) Liability was -1.3 percent in 2010, and +2.3 percent for PPA Total. The comparable countrywide numbers are +0.6 percent for Liability and +2.6 percent for PPA Total. This shows that New Jersey auto insurer profitability still is below national averages. However, as noted above in response to other Comments, the Department believes that it is imperative to adopt these reforms as soon as possible not only to achieve cost-containment, but to provide maximization of PIP benefits for insureds, increase the cost-certainty, efficiency, and timeliness of the PIP process for insureds, insurers, and providers, and to combat fraudulent practices in PIP.

COMMENT: One commenter objected to the amendments in the notice of proposed substantial changes because there is no proof that PIP is exerting "upward pressure" on costs; the data used by the Department is stale and doesn't reflect current trends in the cost of PIP; and insurance companies are making a significant profit on automobile insurance. In support of these contentions, the commenter submitted the report of an actuary. The report concluded that: loss ratios for loss and defense containment costs to earned premium decreased in 2010 and 2011; the overall insurance experience for other liability, PIP, and physical damage combined was more favorable to insurance in 2010-2011 than in 2009; the PIP loss cost experience, the average amount paid in losses per insured also known as pure premium, does not show any large patterns of increased cost; and the annual changes in PIP loss costs from 2007 to 2011 are lower than the countrywide average for PIP and lower than the countrywide average for healthcare costs. The commenter concluded by stating that the Legislature and the Department acted aggressively to reduce costs in the 2003 legislative changes and the 2009 regulatory

changes indicate that that there is no valid basis for any further changes at the present time.

RESPONSE: As noted above in response to Comments on the original proposal, the Department does not agree with the commenter that the loss experience or profitability of insurers should determine Department policy on PIP fee schedule rulemaking. The Department has addressed the conclusions of the actuary's report in the Responses to Comments on the original proposal.

COMMENT: One commenter disagreed with the statement in the Social Impact statement that the amendments will promote the cost efficient provision of quality medical care to persons injured in auto accidents. The commenter asserted that most of the amendments will solely benefit insurers. In addition, the commenter believes that the carve-out for hospitals is unfair and anti-competitive. The commenter asserted that the proposed amendments will have a negative impact on insureds and medical providers by reducing necessary testing and treatment and placing obstacles in the way of prompt payment.

RESPONSE: The Department does not agree with the commenter's unsupported opinions. The amendments in the notice of proposed substantial changes on adoption benefit the providers by removing the fees for 117 CPT codes from the Physicians' Fee Schedule pending further study. The Department does not understand what the commenter refers to as the "hospital carve out." Finally, the Department does not agree that the amendments will reduce necessary testing or place obstacles in the way of prompt payment. Rather, the amendments will increase efficiency and cost-certainty, and address overutilization and fraud by certain providers.

COMMENT: One commenter disagreed with the Economic Impact statement in the proposal that stated that the proposal will have a positive economic impact on hospital outpatient facilities and neuro and spinal surgeons. The commenter asserted that any such benefit is made at the expense of other providers such as other surgeons and ASCs. The commenter believed that if the effect of the amendments is to lower PIP costs, the savings will only be to the benefit of insurers who will reduce care and benefits while charging the same premiums.

RESPONSE: The Department does not agree with the commenter. The Department does not understand how not adopting some physicians' fees, which are not on the fee schedule now, will impact other providers. HOSFs will realize an economic benefit because many insurers were reimbursing them incorrectly. The Department also does not agree with the commenter's conclusory statement that insurers will reduce care while charging the same premium. The Department believes that the addition of the new codes to the fee schedules, the internal appeals procedures when implemented, the on-the-papers arbitration process, and the new ASC and HOSF facility fee schedules will combine to provide more efficient and cost-certain provision of PIP benefits and will maximize PIP benefits for all insureds while maintain high-level care for PPA accident victims.

COMMENT: The Department received comments from 24 persons in a form letter that stated that the commenter opposed the original proposal and the amendments in the notice of proposed substantial changes on adoption. The commenter expressed appreciation for the increase in some fees and removals of other fees but stated that the Department had inaccurate information, overreaching ideas, and the changes will likely

harm the consumer. The commenters stated that the sole concern of insurers should be to reduce premiums. The commenters further stated their fear that, "the proposals will delay and deny medically necessary treatment to the detriment of the consumer's health and well being, particularly the internal appeals process, Medicare rates basis, control by the carriers of who can request pre-certification and the counting of days and dispute resolution restrictions." The commenters stated their fear that, if the regulations are approved, they would not be able to find a doctor to treatment them after an accident. Finally, the commenters asked the Department not to adopt the proposed regulation and requested a public hearing.

RESPONSE: The Department does not agree with the commenters' conclusory statements and notes that this form letter is almost identical to one submitted as a comment to the original proposal and which is responded to above.

N.J.A.C. 11:3-4 Personal Injury Protection Benefits; Medical Protocols; Diagnostic Tests

N.J.A.C. 11:3-4.2

COMMENT: Several commenters stated that it would cost time and effort for insurers to revise their DPR Plans. The commenters also believed that allowing each insurer to set its own close of business would cause chaos because there would be substantially different business hours resulting in varying calculations of "days." These commenters recommended that one uniform standard be imposed to prevent chaos. Another commenter stated that the proposed change to the definition of "days" is ambiguous.

RESPONSE: The Department does not agree with the commenter that it should establish

one close of business time for all companies. The Department does not anticipate that the "close of business" time will be that different among the various companies but it will review the times that are submitted for approval in amendments to DPR plans.

COMMENT: One commenter stated that many providers open late and close later to accommodate their patients while insurers run on earlier schedules. The commenter stated that some providers have trouble getting faxes sent to a carrier because of the volume. The commenter asked what happens if the insurer sends out something later than its business day. The commenter questioned whether the insurer would be punished the same way doctors would for sending something beyond the deadline. The commenter believed that requiring providers to check each individual plan for the close of business time would be burdensome.

RESPONSE: The commenter's concern about what would happen if insurers send out notifications later than their business hours is speculative. The Department will monitor the implementation of the internal appeal process when it becomes operative. If such abuses occur, the Department will address them. As noted above in the Response to the Comment above, the Department does not believe that there will be that much difference in the close of business times for insurers. Therefore, it should not be any more burdensome to check business closing time than it is to determine the fax number to send in Attending Provider Treatment Forms or to determine what treatments require precertification.

COMMENT: One commenter supported the inclusion of language directing insurers to include a close of business time in their DPR plans. The commenter believed that this language resolves an issue that was ripe for confusion and exploitation by unscrupulous

providers.

RESPONSE: The Department appreciates the support.

N.J.A.C. 11:3-4.4

COMMENT: Several commenters disagreed with the Department's decision to withdraw the amendments to the original proposal that gave insurers the option to utilize a WCMCO in addition to Organized Delivery Systems in the deductible waiver provision of N.J.A.C. 11:3-4.4. One commenter believed that the proper response to the confusion about the provision is to clarify it, not delete it. The commenter also asserted that the failure of any company to utilize the provision was the result of regulatory uncertainty rather than its potential for cost savings. The commenter urged the Department not to foreclose a potential avenue for savings. Another commenter recounted the history of the provision from the amendments made to N.J.A.C. 11:3-4.4 in 2010 (see 41 N.J.R. 2609(a) and 42 N.J.R. 1385(a)) to the decision to delete WCMCOs in the. notice of proposed substantial changes The commenter stated that the public policy reasons for the inclusion of WCMCOs are as valid today as they were in 2010. The commenter asserted that by reversing course, the Department was favoring ODSs over other entities that provide PIP services to insurers. The commenter noted that this will impact the marketplace in a negative manner since insurers looking to offer the benefits of N.J.A.C. 11:3-4.4(d) to their insureds will be required to contract with an ODS at rates that are less favorable than those of an WCMCO and with fewer choices in the marketplace. The commenter does not believe that the proposed elimination of WCMCOs from N.J.A.C. 11:3-4.4(d) will alleviate confusion but will create more confusion and disruption to the marketplace. Another commenter stated that the concerns of commenters to the original

proposal that the use of WCMCOs would apply workers' compensation managed care provisions to PIP were misplaced. The commenter urged the Department to retain the provision since it would create efficiencies and result in cost savings that ultimately benefit policyholders.

RESPONSE: The Department does not agree with the commenters. The Department proposed the addition of subsection (d) to N.J.A.C. 11:3-4.4 in 2010 at the suggestion of a PIP vendor. The comments to that proposal requested that WCMCOs, among other payors, be added to ODSs as entities that with networks that insureds could use to obtain treatment services. In the adoption of the 2010 proposal, the Department agreed that WCMCOs and other payors should be added to ODSs. The Department subsequently issued a Bulletin permitting insurers to file amendments to implement the provisions in N.J.A.C. 11:3-4.4(d) to use an WCMCO in addition to an ODS. No insurers filed policy language to waive deductibles when treatment is provided by an ODS, a WCMCO,or any other type of provider network. This indicated to the Department that insurers were not interested in taking advantage of this provision. The lack of insurer interest and the fact that so many providers were confused about how WCMCOs would be used in this process has convinced the Department to delete WCMCOs from N.J.A.C. 11:3-4.4(d).

COMMENT: Several commenters thanked the Department for removing WCMCOs from N.J.A.C. 11:3-4.4(d).

RESPONSE: The Department appreciates the support.

N.J.A.C. 11:3-4.9

COMMENT: One commenter believed that the re-inclusion of the provision permitting

insurers to include in their assignment of benefits a provision that providers acting on assignment agree to submit disputes to arbitration does not allow the insured to seek other means of dispute resolution.

RESPONSE: The Department does not agree with the commenter. The provision simply requires that the provider acting on an assignment of benefits utilize the arbitration system before seeking relief in Superior Court. It does not prevent such suits.

COMMENT: One commenter noted that the amendments to N.J.A.C. 11:3-4.9(a) did not include a reference to a power of attorney. The commenter stated that if the Department has retained the references in other parts of the rule to powers of attorneys, similar language should be included here.

RESPONSE: The Department agrees with the commenter that it would be appropriate to include a reference to powers of attorney in this section to clarify that providers can not evade the requirements of an assignment by using a power of attorney. However, such a change would be a substantial change upon adoption requiring additional notice and public comment. The Department will amend the provision to include a reference to powers of attorney in future rulemaking.

COMMENT: One commenter asked why the Department in the amendment to N.J.A.C. 11:3-4.9(a) was allowing insurers to make arbitration mandatory for providers when much of the other amendments are geared towards arbitrarily reducing and/or eliminating arbitrations. The commenter believed this provision should be deleted.

RESPONSE: The Department does not agree with the commenter. The Department inadvertently proposed the deletion of N.J.A.C. 11:3-4.9(a)3. Insurers should have the

ability to require that providers utilize arbitration for dispute resolution prior to going to court.

N.J.A.C. 11:3-5 Personal Injury Protection Dispute Resolution

N.J.A.C. 11:3-5.6

COMMENT: Several commenters objected to the clarification of the circumstances where payment of an award is stayed pending various post-decision actions, such as requests for clarification, appeals, and the filing of an action in Superior Court. The commenters believed that payment of an award should not be stayed for any reason. The commenters asserted by using such procedures, an insurer could delay payment of the award for up to 195 days.

RESPONSE: The Department does not agree with the commenter. Parties are entitled under the Department's rule to take certain post-decision actions such as requests for clarification and appeals. Payment of the award cannot be made until it is clear whether requests for such actions will be filed. As noted below in the Response to another Comment, the purpose of these rules is not to promote or impede post-decision actions by the parties.

COMMENT: One commenter stated that the proposed change to N.J.A.C. 11:3-5 concerning stays of payment of the award is inconsistent with the 35-day deadline in the PIP Arbitration Rules of the administrator of the program, Forthright. The commenter also asserted that the amendment does not make any reference to attorney fees and costs. The commenter believed that it would be better to specify that the language includes attorney fees and costs, rather than assuming it. The commenter also stated that most

requests for clarifications are filed frivolously and the proposed amendment will only cause more of such behavior.

RESPONSE: The Department does not agree with the commenter. The Department's rules govern and the Arbitration Administrator will amend its rules for post-decision stays when the Department adopts the amendment to its rule. The Department does not believe that it is necessary to specifically mention attorney fees and costs. These are components of the decision and would be included in any stay. The purpose of the amendment is not to promote or impede post-decision actions by the parties but rather to establish reasonable time frames for stays to allow the post-decisions actions to take place while the status quo is maintained because if post-decision relief is successful and the award has already been paid, it can be difficult and complex for the insurers to attempt to recover the reduced amounts from the various parties to the award.

N.J.A.C. 11:3-5.12

COMMENT: One commenter stated that it believed that a post-employment restriction did fall within the authority of N.J.S.A. 39:6A-5.1.b. The commenter acknowledged that the Rules of Professional Conduct do contain sufficient guidance for attorney DRPs but suggested that the Department reconsider a post-employment restriction for non-attorney DRPs.

RESPONSE: The Department notes that at this time there are no non-attorney DRPs. If any non-attorney DRPs are hired by the Arbitration Administrator, the Department will reconsider the restriction.

COMMENT: One commenter appreciated the Department's decision to delete N.J.A.C.

11:3-5.12(f) which restricted the post-employment of DRPs. The commenter believed that the Department had no need or authority for the provision and noted some other provisions that the commenter believed also lacked authority, including N.J.A.C. 11:3-4.7(c)6, 4.7(c)8, 4.7B, and 5.6(e), and referenced comments made to the original proposal.

RESPONSE: The Department appreciates the support for the deletion of N.J.A.C. 11:3-5.12(f) and refers the commenter to the Responses to Comments to the original proposal.

N.J.A.C. 11:3-29 Medical Fee Schedules: Automobile Insurance Personal Injury Protection and Motor Bus Medical Expense Insurance Coverage

COMMENT: One commenter appreciated the opportunities for dialogue that the Department provided during the process of crafting the proposed rules. The commenter supported the proposed new Appendix, Exhibit 7 that provides a separate schedule for HOSF fees. The commenter also supported the amendments to N.J.A.C. 11:3-29(a)2 through 5 that distinguish between ASCs and HOSFs and the services that can be provided in each type of facility. The commenter supported setting the HOSF fee schedule at 300 percent of the 2011 geographically wage-adjusted Medicare Outpatient Department fees for Bergen and Atlantic Counties representing the North and South regions, respectively. Finally, the commenter supported the amendment to N.J.A.C. 11:3-29.4(a)2, which clarified that the fees in Appendix, Exhibit 7 do not apply to services provided in emergency rooms.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter stated that the amendments in the notice of proposed

substantial changes should not be adopted because they do not promote the cost-efficient provision of insurance coverage required by N.J.S.A. 39:6A-4 et seq. The commenter asserted that most of the proposal is solely for the benefit of insurance companies and acts to the detriment of injured persons and providers. The commenter believes that the Department should focus on the abuse of the ambiguity in the proposed amendments. The commenter stated that many insurers and especially their vendors harm consumers and the providers who treat them by routinely denying treatment without performing the proper reviews or delay treatment by requesting records that have already been provided. The commenter asserted that these improper delays and denials of legitimate claims are driving up the cost of PIP and result in arbitrations being filed.

RESPONSE: The Department believes that the comment is outside the scope of the notice of proposed substantial changes since it does not refer to any specific amendments made in the notice of proposed substantial changes that are ambiguous and subject to abuse. The Department notes that it monitors insurer actions through complaints and Market Conduct Examinations, and invites the commenter to file any specific complaints for the Department's investigation regarding alleged insurer delays.

COMMENT: One commenter noted that N.J.S.A. 39:6A-6.a requires that the Department review the fee schedules every two years for inflation adjustments. The commenter stated that in previous amendments to the fee schedules, the Department made specific reference to inflation adjustments citing the United States Department of Labor Statistical Areas that comprise New Jersey. The commenter claimed that in the current proposal, the Department has disregarded this statutory requirement.

RESPONSE: The comment is beyond the scope of the notice of proposed substantial

changes since, with the exception of some corrections, no existing fee schedules were updated in this notice.

COMMENT: One commenter asked for clarification as to whether the effective date of the amendments in the notice of proposed substantial changes is policy effective date-driven.

RESPONSE: This notice of adoption states the effective and operative dates for all the adopted amendments and new rules.

COMMENT: One commenter objected to the incorporation of Medicare rules for coding, including the NCCI edits in the fee schedule rules. The commenter noted that Medicare is an insurer of last resort and that Medicare fees are largely based on budget restraints and do not represent the 75th percentile of provider fees as required by statute. The commenter further noted that many doctors in New Jersey do not accept Medicare patients and an increasing number of providers do not accept PIP patients, which makes it difficult for the consumer.

RESPONSE: The Department does not agree with the commenter. Medicare is the largest health payor in the country and its fees and rules are developed in a transparent manner and are used by many health payors. As discussed more fully above in response to comments to the original proposal, the Department uses the Resource-Based Relative Value Units developed by CMS to calculate the fees on the fee schedules. The Red Tape Review Commission – Findings and Recommendations, February, 2012, stated "Executive Order No. 2 requires State agencies to not exceed the requirements of federal law except when required by State statute or where exceeding federal requirements is necessary to achieve a New Jersey specific public policy goal. A corollary of that

principle is for New Jersey to adhere to nationally accepted standards, where appropriate." The Department believes that it is appropriate to follow these national standards.

COMMENT: One commenter requested that the Department retain an outside firm to go over all the fee schedules and verify their accuracy. The commenter stated that the stakeholders do not have the ability to go through everything line by line. The commenter believes that having an outside independent review would benefit everyone.

RESPONSE: The Department will consider the commenter's suggestion for future rulemaking.

COMMENT: One commenter asked the Department to redo the Exhibits to the rule. The commenter recognized that this would be a substantive change on adoption. The commenter stated specifically that the Physicians' Fee Schedule should be separate from the ASC fee schedule. The commenter also recommended that the Physicians' Fee Schedule should state where the procedure can be performed and list UCR where appropriate. Another commenter asked that the Department confirm the accuracy of the fee schedules. The commenter believes that there is substantial confusion as to which physician fees are included on the fee schedule and which are to be paid at UCR. The commenter also requested that there should be a separate fee schedule that clearly delineates in what context (ASC or HOPD), the procedures can be performed. The commenter stated that without such a clarification, it cannot be said that there was a meaningful notice and comment period for the amendments in the notice of proposed substantial changes.

RESPONSE: The Department does not agree with the commenters that the Exhibits to

the rule are confusing. Any CPT code for which there is no physician fee on Exhibit 1 or which is not included in Exhibit 1 is payable at UCR. If a specific physician's usual and customary fee for a CPT code on the schedule is less than the fee schedule amount, then that specific physician should request and be reimbursed at that lesser usual and customary fee. As noted above, the Department's rules have always stated that providers should be reimbursed at the fee schedule amounts or UCR, whichever is lower. And, it is obvious that if a CPT code is not on the fee schedules then it must be reimbursed at UCR. The Department also does not agree that it is necessary to clarify which procedures can be performed in an HOSF and which can be performed in an ASC because this is clear in the adopted Exhibits. The adopted new rule and amendments do not impose any restriction on the procedures that can be performed in an HOSF. For an ASC, only the procedures for which there are CPT codes with fees in the ASC fee column of Appendix, Exhibit 1 can be performed in an ASC. The Department also does not agree that there has not been meaningful notice and comment to the proposals. As discussed above in response to comments to the original proposal, the Department met with many groups of interested persons in developing the rules and provided access to the exhibits before they were proposed, in addition to the formal rulemaking process which began in August 2011.

N.J.A.C. 11:3-29.1

COMMENT: One commenter noted the language in N.J.A.C. 11:3-29.1(d)4, "Inpatient services provided by acute care hospitals, trauma centers, rehabilitation facilities, other specialized hospitals, residential alcohol treatment facilities and nursing homes, except as specifically set forth in this subchapter," and asked that the text be revised to provide

further clarification regarding rehabilitation facilities. The commenter noted that the notice of proposed substantial changes added a definition of "hospital" and suggested that the Department provide a definition of "other specialized hospital" as used in N.J.A.C. 11:3-29.1(d)4. The commenter also requested that the Department provide guidance on what rehabilitation facilities are to be reimbursed, along with reimbursement amounts for specialized hospitals, residential alcohol treatment facilities, and nursing homes.

RESPONSE: The Department does not understand the comment. The fee schedule rule does not apply to the facilities listed in N.J.A.C. 11:3-29.1(d)4. The Department has no plans at the present time to propose a hospital fee schedule.

N.J.A.C. 11:3-29.2

COMMENT: One commenter noted that the Department has added the definition of "ambulatory surgical case" back into the rule. The definition of ambulatory surgical case excludes those procedures that meet the definition of "minor surgery" in N.J.A.C. 13:35-4A.3. The commenter stated that some codes that have facility fee amounts in the ASC fee schedule section of Exhibit 1 would meet the definition of minor surgery in N.J.A.C. 13:35-4A.3. Two examples are CPT 20553, Trigger Point Injections, and HCPCS 0232T, Platelet Rich Plasma injections. The commenter asked if it was the Department's intent to allow procedures similar to those noted above to be eligible for facility reimbursement in an ASC or HOSF?

RESPONSE: The Department notes that the rule currently in effect contains both the definition of minor surgical procedure and the CPT codes mentioned by the commenter. The Department is not aware of any conflicts involving payment for these codes. The Department will review whether facility fees for certain codes ought to be removed from

the ASC fee schedule as minor procedures and, if so, will make such changes in future rulemaking.

COMMENT: One commenter stated that it disagreed with the statement in the Summary of Public Comments and Agency Responses concerning the definition of ambulatory surgical center stating that only Medicare accredited or certified physician-owned single operating rooms are eligible to receive facility fee. The commenter stated that there are many privately accredited single operating room facilities in New Jersey that charge a facility fee. The commenter stated that there were so many privately accredited single operating rooms that a law had to be enacted to register them and find out how many there were. The commenter requested that the definition of ambulatory surgical center be amended to either include unlicensed privately-accredited single operating room facilities or be limited to outpatient facilities that are either licensed by the State or certified by Medicare.

RESPONSE: The Department notes that the comment refers to the text of a Departmental Response to a Comment on the original proposal. The Department accepts that it was in error in stating that the only single operating room facilities that can receive a facility fee are those certified by Medicare. However, the Department has determined that no change to the rule is necessary. The amendment to the rule in the notice of proposed substantial changes limits the payment of facility fees for single-room operating rooms to those certified by Medicare, suggested as one alternative by the commenter. Further, the amendments to the rule in the notice of proposed substantial changes on adoption restored the prior definition of ASC to the rule.

COMMENT: One commenter recommended that the definition of “ambulatory surgical

center" should be amended to reference an accredited entity or provide guidance on other licensed/registered accreditations that meet a standard of quality that is acceptable.

RESPONSE: The Department does not agree with the commenter. The Department uses the Department of Health and Senior Services' definition of an ASC plus single operating rooms certified by Medicare. As noted above in response to another Comment, in the amendments in the notice of proposed substantial changes on adoption, the Department simply restored its previous definition of an ASC to the rule. The commenter did not provide any reasons why the definition should be changed.

COMMENT: Several commenters supported the change in the definition of "outpatient surgical facility" made in the notice of proposed substantial changes on adoption. The commenters believed that the original definition would have included doctor's offices.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter asked for clarification regarding the reimbursement for services submitted with an unlisted procedure code. The commenter asked whether it should deny the whole bill when the primary procedure is an unlisted code on the basis that the whole procedure is too complicated to be performed in an ASC. The commenter also asked how it was to determine whether a UCR code can safely be performed in an ASC setting.

RESPONSE: N.J.A.C. 11:3-29.5(a) states that the only procedures performed in an ASC that are eligible for reimbursement are those that are listed with a fee in the ASC column of Exhibit 1. Since Exhibit 1 does not contain any "unlisted" codes, no such procedure is reimbursable if performed in an ASC. The Department assumes that "UCR codes" as

used by the commenter means codes that are not on fee schedule. As noted above, the only codes that are reimbursable if performed in ASC are those codes that have an amount in the ASC fee column in Exhibit 1.

N.J.A.C. 11:3-29.4

COMMENT: One commenter recommended that the Department elaborate on trauma services provided by a physician in a Level 1 or Level 2 Trauma Center. The commenter also seeks additional clarification of emergency care and trauma guidelines, including the time frames when trauma and emergency care is no longer applicable.

RESPONSE: The comment is outside the scope of the notice of proposed substantial changes on adoption. A definition of "trauma services" was proposed in the August 1, 2011 original proposal and was not amended in the notice of proposed substantial changes. N.J.A.C. 11:3-29.4 already contains a definition of "emergency care."

COMMENT: One commenter supported the amendments to N.J.A.C. 11:3-29.4(a)4, which clarifies that, with certain exceptions, the Fee Schedule applies regardless of the site of service.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter asserted that there was a possibility for confusion between the language in N.J.A.C. 11:3-29.4(a)4, which states that, "except as provided in (a)1 through 3 above, the fees in Appendix, Exhibits 1 through 7 apply regardless of the site of service," and the "except as specifically set forth in this subchapter," language of N.J.A.C. 11:3-29.1(d)4. The commenter suggested rewording these sections to avoid any confusion in their application.

RESPONSE: The Department does not agree with the commenter. N.J.A.C. 11:3-29.1(d)4 refers to the whole subchapter, the rules and the fee schedules. There are certain rules which apply to PIP benefits regardless of where they are provided such as the provisions in N.J.A.C. 11:3-29.4(a), which state that only medically necessary services are reimbursable. N.J.A.C. 11:3-29.4(a)4 refers to the application of the fee schedules in Appendix, Exhibits 1 through 7.

COMMENT: One commenter suggested that N.J.A.C. 11:3-29.4(b)2 be amended upon adoption to refer to "multiple surgical procedures" to clarify that the multiple procedure reduction formula applies only to surgical codes. The commenter asked if the bilateral procedure rule applies to codes performed in ASCs even if they are not subject to the multiple procedure reduction formula.

RESPONSE: The Department does not agree with the commenter. N.J.A.C. 11:3-29.4(b)2 already refers to multiple procedures performed in an ASC or HOSF in the same *operative session* (emphasis added), which indicates that it refers to surgical procedures. Surgical procedures are more likely to be performed in ambulatory *surgical* centers and hospital outpatient *surgical* facilities (emphasis added). Concerning bilateral procedures, the Department has already made it clear in its Frequently Asked Questions page on its webpage (http://www.state.nj.us/dobi/pipinfo/medfeeqa.htm) that the rules for bilateral procedures apply only to physicians' services, not to ASC facility fees. If there is continuing confusion, the Department will consider clarifications in future rulemaking.

COMMENT: One commenter submitted the same comment on the notice of proposed substantial changes as was submitted on the original proposal. The commenter, referencing N.J.A.C. 11:3-29.4(g), stated, "There are no payment guidelines for handling

DMEPOS payment classes OS (Ostomy, Tracheotomoy and Urological); S/D (Surgical Dressing); or SU (Supplies, DME) within the Medicare Claim Processing Manual. Please confirm recommended handling for these payment classes are in accordance with fee schedule allowance."

RESPONSE: The comment is outside the scope of the notice of proposed substantial changes on adoption. The text of paragraph (g) in N.J.A.C. 11:3-29.4 was not amended in the notice of proposed substantial changes on adoption.

COMMENT: One commenter recommended adding the AMA CPT Professional Edition Guidelines to the list of publications to be used to interpret usage of codes on the fee schedule.

RESPONSE: The Department is not familiar with the publication but will determine if it is appropriate to be included in the list of publications in future rulemaking.

COMMENT: One commenter appreciated the clarification to N.J.A.C. 11:3-29.4(g)6 that supplies are included in rentals of TENS and EMS units.

RESPONSE: The Department appreciates the support.

COMMENT: One commenter noted that at N.J.A.C. 11:3-29.4(g)9 in the original proposal, the Department included information on how HCPCS code G0289 should be billed. The commenter advised that since the publication of the proposal, the AMA has changed its position and has revised CPT 29880 and 29881 to include chondroplasty. As a result, CMS has amended the NCCI to not allow any payment for G0289. The commenter asked whether it was the Department's intent to bypass the NCCI edits for G0289.

RESPONSE: The comment is outside the scope of the notice of proposed substantial changes on adoption because N.J.A.C. 11:3-29.4(g)9 was not amended in the notice of proposed substantial changes. The Department agrees with the commenter that the descriptions of CPT codes 29880 and 29881 were changed in the 2012 edition of the CPT manual to include the chondroplasty covered by G0289. Making this change on adoption would be a substantial change requiring additional notice and public comment. Payors and providers should follow the guidance in N.J.A.C. 11:3-29.4(e) for codes that have changed since the rule was adopted.

COMMENT: Several commenters noted that N.J.A.C. 11:3-29.4(g)6 states that leads, pads, and electrodes for a TENS or EMS unit are included in the rental fee but are separately reimbursed if the unit is purchased. The commenters stated that a purchased TENS or EMS unit comes with a month's worth of supplies and recommended that the rule be amended upon adoption to clarify that a month's worth of supplies be included in the purchase price of the unit. Another commenter suggested the following language to express this change:

"The first month's supply of leads, pads, batteries and any other supplies for TENS or EMS devices are included in the purchase of a unit, and are not separately reimburseable. All such supplies are included in the rental fee for the duration of a rental of the unit, and are not separately reimburseable."

RESPONSE: The Department agrees with the commenters that the rule should be clarified to indicate that the first month of supplies are included in the purchase of a unit and has added the following second sentence to N.J.A.C. 11:3-29.4(g)6 upon adoption:

"For purchase of the unit, the first month's supply of leads, pads, batteries and any other supplies for TENS or EMS units are included."

N.J.A.C. 11:3-29.5

COMMENT: One commenter stated, "[N.J.A.C. 11:3-21.5] references use of Medicare ASC fee schedule. Please confirm if intent is to use the most recent Medicare fee schedule for applicable rules and fees."

RESPONSE: The Department does not understand the comment. The referenced section does not contain a reference to the Medicare ASC fee schedule. In any case, payors should use the fees in the ASC column of Appendix, Exhibit 1, not Medicare fees.

COMMENT: One commenter asked for confirmation that in Exhibits 1 and 7, an "N1" in the "Packaged Item: No Separate Payment" column indicates that the items are ancillary to surgical procedures and are not permitted to be reimbursed separately in either an ASC or hospital outpatient department, while "AS" indicates that although the items are ancillary, a separate reimbursement is possible.

RESPONSE: The Department agrees with the commenter in part. Exhibit 1 does not have a column entitled, "Packaged Item: No Separate Payment." Rather, it has a "Payment Indicator" column in which the code N1 means that the item is packaged and cannot be reimbursed separately in an ASC. Exhibit 7, the Hospital Outpatient Surgical Fee Schedule, has two columns, one of which is entitled "Packaged Item; No Separate Payment" and the other is entitled, "Ancillary Services; Separate Payment." The Department agrees that these codes mean what the commenter stated.

COMMENT: One commenter asked for, "clarification for non-implantable devices

furnished in an ASC or HOSF."

RESPONSE: The Department does not understand the comment. The facility fee for an ASC or HOSF includes implantable DME or prosthetics. Non-implantable devices would be billed according to the DME fee schedule.

COMMENT: One commenter noted that while the proposed amendments in the notice of proposed substantial changes on adoption acknowledged that fees for services in hospital outpatient departments were higher than those in ASCs, the Department was encouraging procedures to be performed in hospitals.

RESPONSE: The Department believes patient safety cannot be jeopardized in an effort to maximize cost control. As noted in prior Responses, the Department has determined according to its authority in N.J.S.A. 39:6A-4 that it is only reasonable to reimburse facility fees for a limited number of procedures under PIP when performed in an ASC according to the Medicare determinations based upon patient safety.

COMMENT: One commenter disagreed with the limitation on the procedures that can be performed in an ASC. The commenter also disagreed that the restriction on the procedures is based on CMS concerns about patient safety. The commenter stated that what gets on the Medicare ASC fee schedule goes beyond patient safety and includes other concerns. Several commenters provided copies of the New Jersey Department of Health and Senior Services – Patient Safety Reporting System 2009 report, the most recent available. The report states that there were only 48 adverse events in licensed ASCs out of more than 100,000 procedures performed, including procedures that could only by performed in HOSFs pursuant to the notice of proposed substantial changes on adoption.

RESPONSE: The Department does not agree with the commenters. As noted in the Comments and Responses to the original proposal that were included in the notice of proposed substantial changes on adoption, CMS decisions on the procedures that can be performed in an ASC are based on an analysis of patient safety. N.J.S.A. 39:6A-4 states that the Commissioner shall approve a PIP medical benefit plan for "reasonable, necessary and appropriate treatment and provisions of services." The statute goes on to state that, "[M]edical treatments, diagnostic tests, and services provided by the policy shall be rendered in accordance with commonly accepted protocols and professional standards and practices which are commonly accepted as being beneficial for the treatment of covered injury." The Department has decided to utilize the standards established by one of the nation's largest payors, Medicare, for determining which procedures may be safely performed in an ASC. The fact that relatively few adverse events have been reported in ASCs does not meet the statutory standard for deciding which procedures can be performed in these facilities.

COMMENT: Several commenters stated that it was inappropriate for the Department to use Medicare fees, rules, and edits for PIP. The commenter asserted that Medicare rules and guidelines are for Medicare patients, who generally consist of the elderly and disabled. The general public, especially PIP patients, are generally younger and healthier and more suitable for care in an outpatient facility. One commenter stated that the appropriateness of the patient for the procedure should be the driving consideration and that ASCs do a good job of policing themselves. This commenter asserted that no responsible ASC would do a procedure that it was incapable of safely performing. Another commenter stated that by limiting the procedures that can be performed in an

ASC, the Department is usurping medical decision making and limiting patient access.

RESPONSE: The Department does not agree with the commenters. As noted above, the Department is complying with its statutory obligation to establish fee schedules for the reimbursement of reasonable, necessary and appropriate medical treatments and this analysis includes an evaluation of whether the location for provision of the service ensures patient safety. The Department notes that the CMS guidelines on which procedures can be safely performed in an ASC are based on specific criteria rather than the determination of the ASC, which may be influenced by the financial interest of the physician owners of the facility. The restrictions on procedures that can be performed in ASCs is not limited to Medicare patients but also applies to Medicaid (see N.J.A.C. 10:66-5.1). The Department does not believe that the application of objective standards on the procedures that can be performed in ASCs limits medical decision making or access to care, as the procedures that cannot be performed in ASCs can be performed in HOSFs or hospitals. However, the Department notes that it has the authority to make certain restrictions as discussed above and affirmed by the Appellate Division in *Coalition II*.

COMMENT: One commenter noted that the decision on the appropriateness of procedures that can be done in an ASC was based on a 2007 study commissioned by CMS. The commenter stated that the technology from 2007 to 2012 is light years different and continues to change rapidly. What might have been considered inappropriate in 2007 would not be the same now.

RESPONSE: The Department does not agree with the commenters. Although the initial standards for procedures that can be performed in ASCs were developed in 2007, CMS

reviews the procedures that can be performed in an ASC every year and updated the codes that can be performed in ASCs.

COMMENT: Several commenters stated that in addition to offering a high level of patient safety and medical care, ASCs allow surgeons to perform cases more efficiently. The commenters cited an article in which a spine surgeon reported that the turnaround time between procedures at his ASC is 12 minutes compared to an hour and 20 minutes at a local hospital. The commenters asserted that the shorter turnaround time is attributable to the specialized nature of ASC operation rooms, especially single-specialty ASCs. The commenters stated that spine surgeries can be performed for a 60 percent cost savings at an ASC compared to a hospital and that most of this savings is a result of reduced time associated with the procedure. The commenter asserted that the proposed changes will increase costs to insureds and insurers.

RESPONSE: The Department does not agree with the commenters. Efficiency for the surgeon or cost savings for the insurer cannot take precedence over the Department's statutory obligation to determine appropriate treatments and tests and established and widely accepted national standards for patient safety, which, as noted above in the Response to another Comment, are the bases for the restrictions.

COMMENT: One commenter disagreed with the statement that the codes removed from the ASC fee schedule represent a small percentage of the total number of procedures performed in an ASC and would not negatively impact the operators of such facilities. Several commenters noted that Pain Management, Spine, and Orthopedics are the procedures performed most frequently on PIP patients and represent 85 to 90 percent of total PIP cases. The commenter stated that these are the most lucrative codes for ASCs,

so their deletion can affect the bottom line for an ASC. One commenter noted that there are ASCs that are built and operated to specialize in spinal procedures and depend upon them for a large part of their business and thus would be affected by their deletion.

RESPONSE: The Department does not agree with the commenters. Payments under PIP coverage constitute less than three percent of the total amount spent on health-care services in New Jersey. The Medicare Payment Advisory Commission's March 2012 Report to Congress (www.medpac.gov) includes a chart showing the distribution of services performed in ASCs by payors in Pennsylvania in 2010. The chart shows that 53.1 percent of services performed were paid for by commercial payors, that is, health insurers, PPOs, HMOs, etc, while 34.2 percent of procedures were paid for by Medicare and 4.5 percent by Medicaid. Only 8.2 percent of procedures performed were paid for by "Other" payors, which included auto insurance, worker's compensation and other government payors. Even acknowledging that New Jersey's high PIP limits would certainly put a higher proportion of procedures into the "Other" category, it would still be a small fraction of the procedures paid for by commercial payors and Medicare. Therefore, the Department does not believe that the patient safety restrictions on the procedures performed in ASCs will have a significant impact on most ASCs. There may be a higher impact on ASCs that specialize in spinal care, which the commenter acknowledged are the most profitable procedures. However, these financial concerns cannot outweigh patient safety concerns.

COMMENT: One commenter stated his belief that one of the chief reasons for the PIP regulations was cost reduction to the policy holder, the patient. The commenter asserted that requiring that certain codes be performed only in HOSFs would dramatically

increase costs and deprive the patient of the ability to choose to have a procedure done in a less costly ASC. The commenter noted that in addition, some procedures could only be done in a hospital, which would raise the cost even more.

RESPONSE: As noted above in the Response to another Comment, cost reduction is a secondary concern to patient safety.

COMMENT: One commenter stated that the Department has not considered the provider who may be a partner/owner of an ASC and whose operating agreement may prevent him from taking his business to an HOSF.

RESPONSE: The Department does not believe that the financial interests of physician owners of ASCs should take precedence over patient safety. The Department notes that the fact that a physician has an ownership interest in an ASC and may not be able to perform procedures in an HOSF might provide incentives for the physician to perform procedures in an ASC that are potentially dangerous to the patient.

COMMENT: One commenter stated that the limitation on procedures that can be performed in an ASC appears to be an attempt to reduce the number of procedures performed in ASCs. The commenter agreed that there is fraud in the system but stated that the Department has taken a meat cleaver approach when a scalpel would have sufficed. The commenter asserted that insurers could easily check the credentials of a doctor as part of the pre-certification request. The commenter stated that the procedures are going to be performed even if they are done in a hospital, which has a much higher cost. The commenter urged the Department to consult with stakeholders since when an ASC credentials a doctor, it determines which procedures the doctor can perform.

RESPONSE: The Department does not agree with the commenter. As noted above in response to other Comments, the basis for the restriction on the procedures that can be performed in an ASC is implementation of the Department's statutory obligation to determine the appropriateness of treatment and it is based upon CMS's comprehensive national standard. The Department is not aware of any similar comprehensive national standard that governs credentialing of a doctor in a facility.

COMMENT: One commenter stated that the limitation on procedures that can be performed in ASCs will limit patients' access to healthcare because hospitals will have to prepay for any hardware or devices to be used in the operation and a hospital and they will not permit a surgery to take place unless it has been pre-approved by the insurer. The commenter stated that ASCs would take the risk and perform surgeries for which the insurer had denied pre-approval and then file arbitrations. The commenter recommended that the Department have an expedited arbitration procedure for such cases.

RESPONSE: The Department does not agree with the commenter that the rule will limit patients' access to health care. If the insurer has not precertified a surgical procedure to be performed in an ASC, it should not be performed. The provider can appeal such a decision through the insurer's internal appeal process and then through an optional rapid review process for medical procedures that have not yet been performed. The rapid review process is done by an MRO after an arbitration has been filed.

COMMENT: One commenter stated that after reviewing Exhibits 1, 2, and 7, it appeared that the Department had either intentionally or inadvertently omitted the majority of the CPT codes that are considered standard of care and medically necessary for many injured patients. The commenter believed that it did not make rational sense to remove the most

commonly used pain procedures, which are routinely and safely performed in ASCs. The commenter noted that the facet codes had not been removed and stated that there did not appear to be any logical reason for this. The commenter could not find any evidence that the changes were made based on safety, equipment requirement or cost and noted that a facet injection carried the same risk, intensity, need for monitoring, required training and relative value as an epidural injection.

RESPONSE: The Department assumes that the commenter is referring to the determination of the Department in the original proposal not to reimburse for certain types of surgical procedures performed in ASCs on grounds of patient safety. The comment is, therefore, outside the scope of the notice of proposed substantial changes since no fees were removed from the ASC fee schedule in the notice. As noted above in response to other Comments, the limitation on procedures that can be performed in are based on national standards for patient safety.

COMMENT: One commenter pointed out that the majority of pain management services has been routinely provided in ASCs for many years. The commenter stated that ASCs are the ideal location for the performance of pain management procedures because the treatments are elective, and often require sedation, specialized equipment and a short stay afterwards. The commenter asserted that forcing procedures into hospitals would result in inadequate equipment to accommodate many of the required techniques and would limit patient choice.

RESPONSE: The Department does not agree with the commenter. As noted above in response to other Comments, the basis for the restriction on the procedures that can be performed in an ASC is implementation of the Department's statutory obligation to

determine the appropriateness of treatment and it is based upon CMS's comprehensive national standards for patient safety in ASCs.

COMMENT: Several commenters opposed the limitation on the procedures that can be performed in an ASC noting that ASCs in New Jersey are held to a high standard of safety and quality. They must satisfy very specific criteria regarding patient safety mechanisms, infection prevention, facility policies and procedures, and physical plant requirements. In addition, the commenters stated that both the New Jersey Department of Health and Medicare survey and inspect licensed ASCs regularly to verify compliance with regulatory standards. The commenter stated that New Jersey hospitals are not required to undergo such routine inspections. The commenters also noted that ASCs are also required to get accreditation by a nationally recognized accreditation organization such as the Joint Commission on Accreditation of Health Care Organizations (JCAHO). The commenters asserted that because ASCs are required to comply with such stringent safety standards, they are successful in maintaining very low infection rates and ASC patients are less likely to require unscheduled follow-up care at an emergency department or hospital within one week of surgery. The commenters also stated that ASCs are a critical part of the healthcare delivery system in New Jersey.

RESPONSE: The Department does not agree with the commenters. The Department is not questioning the safety mechanisms and infection prevention measures in ASCs. As noted above in response to other Comments, the basis for the restriction on the procedures that can be performed in an ASC is implementation of the Department's statutory obligation to determine the reasonableness and appropriateness of treatment and it is based upon CMS's comprehensive national standards for patient safety in ASCs.

COMMENT: Several commenters stated that the statement in the Summary that the limitations on procedures that can be performed in an ASC "will not negatively impact the operators of such facilities" and "affect only 24 codes," is incorrect and misleading. The commenter asserted that the number of codes that cannot be performed in ASCs is 83, not 24. The commenters also stated that the number of CPT codes that can be performed in an HOSF but not in an ASC is 41. The commenters noted that even if the number of CPT codes that cannot be performed in ASCs might be a small percentage of the total codes performed in ASCs, such codes account for the overwhelming number of PIP cases. The commenters stated that the proposed changes would have a substantial and devastating affect on ASCs and would force such procedures to be performed at hospitals at a far higher cost to insurers and consumers. The commenters also asserted that there is no statutory authority for the Department to deny payment for procedures performed in ASCs; the Department is usurping the legal authority of the New Jersey Board of Medical Examiners and the Department of Health to determine which procedures physicians may safely perform in ASCs. Another commenter questioned how the Department could make the decision to limit the procedures that can be performed in ASCs without examining the actual experiences of ASCs in New Jersey. The commenters also stated that by setting the reimbursement for certain codes at $0 if performed in an ASC, the changes violate the statutory mandate in N.J.S.A. 39:6A-4.6 to set the fees on the PIP fee schedule at the "reasonable and prevailing rates of 75 percent of the practitioners within the region."

RESPONSE: The Department acknowledges that the number of codes that cannot be performed in an ASC may have been incorrectly stated in the Summary. However, as

noted above in response to other Comments, whether the number of codes is 24, 41, or 83, they are still a very small proportion of the procedures performed in ASCs and should not have a "devastating and substantial effect" on most ASCs. The Department does not agree that it does not have the statutory authority to determine what procedures are reimbursable if performed in an ASC based upon the reasonableness, appropriateness, and necessity of the location of the medical procedure. As noted above in response to other comments, CMS decisions on the procedures that can be performed in an ASC are based on an analysis of patient safety. N.J.S.A. 39:6A-4 states that the Commissioner shall approve a PIP medical benefit plan for "reasonable, necessary and appropriate treatment and provisions of services." The statute goes on to state that, "[M]medical treatments, diagnostic tests, and services provided by the policy shall be rendered in accordance with commonly accepted protocols and professional standards and practices which are commonly accepted as being beneficial for the treatment of covered injury." The Department has decided to utilize the standards established by one of the nation's largest payors, Medicare, for determining which procedures may be solely performed in an ASC. The Department does not believe that that the actual experience of ASCs in New Jersey is an appropriate basis for such a determination. Finally, the Department also does not believe that by using national standards to determine which procedures can safely be performed in ASCs, it is violating N.J.S.A. 39:6A-4.6. That statute governs how fees are to be set on the fee schedules, which is separate from the Department's obligations to establish reasonable and appropriate treatments and it is reasonable to use CMS safety standards to accomplish this. The procedures that are not reimbursable in an ASC can be performed in an HOSF or hospital.

N.J.A.C. 11:3-29 Appendix, Exhibit 1

COMMENT: Several commenters stated that it appeared that the decision to delete the physicians' fees for 117 codes in Exhibit 1 was based on the same data used to establish the other fees on the schedule. The commenter recommended that all decisions be based on true and accurate data that is presented. Another commenter noted that many of the 72 codes that were removed from the Physicians' Fee Schedule are performed very rarely. These commenters questioned whether the Department's goal of cost containment will be met by allowing low volume, high value CPT codes to be paid at usual and customary rates. Another commenter acknowledged that there were not many neurosurgeons in New Jersey and the cost of medical malpractice insurance for that specialty is high, but stated that factor should not solely dictate whether their services should be included in the PIP fee schedule. The commenter asserted that it is not the mandate of PIP to keep these providers solvent. The commenter stated further that leaving the 117 codes to be paid at UCR will allow for the possibility of price manipulation and raise PIP costs for everyone.

RESPONSE: The Department does not agree with the commenters. As noted by the commenters, most of the 117 codes are performed rarely and therefore there is less data available about the appropriate fees for such codes than is available for other codes on the fee schedule. The Department does not agree the number of neurosurgeons in New Jersey was the sole factor in making the decision to delete the codes. Rather, it is a factor in the fact that the procedures are rarely performed. The Department's goal is not solely cost containment but the application of the statutory standard that the fee schedule be comprised of the reasonable and prevailing fees of 75 percent of providers within a

region. The commenters to the original proposal raised sufficient doubt about whether that standard had been met for these codes, accordingly the Department chose to exercise caution and remove them from the Physicians' Fee Schedule pending further study.

COMMENT: One commenter urged the Department to reconsider its decision to delete 117 codes from the Physicians' Fee Schedule. The commenter stated that these codes are typically billed in ASCs and are defined as minimally invasive, non-complex procedures. The commenter also stated that these codes are commonly billed by physicians other than neurosurgeons.

RESPONSE: The Department does not agree with the commenter. As noted below in the Response to another Comment, six of the 117 codes are low-value, high-frequency codes that were removed from the Physicians' Fee Schedule in error. The remaining 111 codes are not minimally-invasive, non-complex procedures. The Department notes that of the 111 codes, only 43 can be performed in ASCs. The remainder must be performed in a hospital inpatient or outpatient facility for patient safety.

COMMENT: One commenter noted that the reason that the Department has a statutory obligation to adopt a comprehensive fee schedule is because, under the current private passenger auto system, insurers are unable to manage care. Insured persons may go to any provider and the insurer must pay the bill without any ability to negotiate the rate. The commenter asserted that in the absence of a comprehensive fee schedule that establishes reasonable reimbursement rates for PIP, the only option left to insurers attempting to control costs is to pay what they deem a reasonable rate and then defend their decision in individual arbitrations – a procedure designed to add cost, with no benefit to anyone other than the attorneys that profit from this process. The commenter

stated that this process leads to a rise in reimbursement rates and an erosion of available PIP coverage for injured drivers, while all New Jersey drivers pay more for less coverage. The commenter noted that it was for this reason that it strongly supported the original proposal because it added costly spine and neurosurgical procedures to the fee schedule. The commenter believed that the fees for these procedures, on average more than 400 percent of Medicare, were excessive but at least they provided a level of certainty to the reimbursements, thus avoiding the costs of re-pricing bills and arbitrations. For these reasons, the commenter opposes the proposed removal of the 111 codes from the rule. The commenter stated that the assertion of physicians that they would cease providing these services if the rates were not raised is specious. The commenter asserted that under the original rule proposal, PIP insurers would remain the most generous payor for these services. The commenter averred that if these procedures are removed from the fee schedule, this group of physicians will continue to reap windfall profits while PIP insureds unfortunate enough need these procedures will quickly exhaust their benefits and be left to look for other sources to finance medical care. The commenter submitted its opinion that the 111 codes remain on the adopted fee schedule.

RESPONSE: The Department does not agree with the commenter. The codes removed were those that the Department believes need more study to determine a proper fee level. Their removal from the fee schedule at this time does not reflect a determination by the Department that they will remain off of the fee schedule indefinitely.

COMMENT: One commenter disagreed with the Department's view that infrequently-used codes should be removed from the fee schedule. The commenter asserted that the premise of a fee schedule is to determine fair values for CPT codes – even if there is

limited billing data available. The commenter also disagreed with the assertion that the adoption of the fee schedule would result in physicians leaving the state. The commenter noted that argument has been used time and again whenever a fee schedule is adopted. The commenter stated that the fact is that New Jersey's PIP reimbursement rates are higher than auto insurance reimbursements in neighboring states such as Pennsylvania, New York, and Delaware and are more generous than the reimbursement paid by health insurers.

RESPONSE: The Department does not agree with the commenter. The codes removed were those that the Department believes need more study to determine a proper fee level.

COMMENT: One commenter stated that the Department offered no data to contrast the surgical codes that were removed from the fee schedule from other pain management codes, for which the commenter believes that there is also little or no data for fee setting.

RESPONSE: The Department does not agree with the commenter. The Department did not remove the codes solely because of insufficient data to determine a fee. The Department identified high-value, low-frequency codes performed by a relative few providers. Pain management procedures do not fall into that category. They are high frequency codes that are performed by many providers. Therefore, pain management codes do not fall within the criteria used to remove the spinal and neurosurgery codes from the fee schedule. Additionally, as discussed above, there is more than sufficient data to develop appropriate reimbursement amounts for pain management procedures.

COMMENT: Several commenters requested the same consideration to people who have balance system dysfunction as has been extended to those individuals who require neurosurgical or orthopedic care as a result of automobile trauma. The commenters

endorsed the Department's rationale for removing the 117 codes for neurosurgeons and spinal surgeons from the fee schedule and requested that the codes for the treatment of balance disorders be removed because there are at most only five physician specialists in New Jersey who have access to the specialized equipment required to comprehensively evaluate a person's balance capacity and the experience in interpreting the results of these investigations and who specialize in the treatment of such patients. The commenters requested that the Department maintain the same level of reimbursement that was in the 2007 fee schedule for such treatments.

RESPONSE: The Department does not agree with the commenter. The Department's decision to remove the 117 codes was not only based on the fact that there were few providers who performed neurosurgical and spine surgery procedures but because the codes are high-value, low-frequency procedures that required more study. The two codes that are mentioned in the comment, CPT 92548 and CPT 92546, are low-value codes. The FAIR Health allowed fee amount at the 95th percentile for CPT 92548 is $131.20 while the amount on the adopted fee schedule is $171.41. The FAIR Health allowed fee amount at the 95th percentile for CPT 92546 is $91.84 while the amount on the adopted fee schedule is $159.00. The Department does not believe that there is any reason to remove these codes from the schedule. Many procedures involve expensive equipment. The cost of that equipment is factored into the Relative Value Unit for the procedure calculated by Medicare and upon which the fee schedules are initially based.

COMMENT: Many commenters pointed out that five of the deleted codes, CPT 64490 through 64495 covering paravertebral facet joint injections, were not on the current fee schedule because they were created in 2010 as replacement codes for CPT 64470, 64472,

64475, and 64476, which are on the current fee schedule. The commenters noted that these codes do not meet the Department's definition of the codes to be deleted since they are neither high value nor uncommon and they urged that the Department consider reinstating these five codes. Several commenters submitted information showing the frequency that these codes are billed. Another commenter stated that adding the codes back in upon adoption would not constitute a substantial change requiring additional notice and public comment. The commenter stated that all parties have already and specifically commented on the removal of the procedures.

RESPONSE: The Department agrees with the commenters. The physician fees for the facet injections, CPT codes 64490 through 64495, were deleted in error. In response to comments received on the August 2011 proposal, in the notice of proposed substantial changes the Department agreed to remove the physician fees for certain high value, low-volume CPT codes that were added to the fee schedule in the August 2011 proposal. As the commenters noted, the CPT codes for facet injections are on the current fee schedule. However, the CPT codes were changed in the 2010 edition of the CPT manual so that they appeared to be new codes that were added to the fee schedule in the August, 2011 proposal. The Department also agrees with the commenters that these codes are neither high-value nor low-volume procedures, the criteria for fees that were deleted from the schedule. Therefore, the Department is declining to adopt the proposed amendment to delete the physician fees for CPT codes 64490 through 64495.

COMMENT: One commenter objected to the fees for EMS and TENS units. Another commenter believed that the proposed fees for EMS and TENS units were irrational, since the Medicare fee schedules have higher amounts for these units, which would be

unfair to the consumer.

RESPONSE: The Department notes the fees for TENS and EMS units were not amended in the notice of proposed substantial changes on adoption and therefore this comment is outside the scope of the notice. The Department has responded to comments concerning these fees above in the Comments Received during the Initial Comment Period, Not Giving Rise to Changes in the Rule Proposal portion of this notice.

COMMENT: Several commenters stated that they believed the Department made an error by omitting CPT 27096 from the ASC fee schedule. One commenter stated that Medicare reimburses ASCs for this procedure using HCPCS code G0260.

RESPONSE: The Department agrees with the commenters. The Department was not aware that Medicare actually has an ASC facility fee for the procedure described in CPT 27096 but uses a HCPCS code to describe it. Since the Department's ASC fee schedule includes ASC fees for all the codes on the Physicians' Fee Schedule that Medicare permits to be performed in ASCs, the Department is amending the rule upon adoption to include an ASC facility fee for 27096. The ASC facility fee is calculated in the same way as the other ASC facility fees, 300 percent of the Medicare ASC fee for HCPCS G0260: $1,012.32 for the North region and $931.80 for the South region.

COMMENT: One commenter stated that they agreed that where an ASC or HOPD facility fee included an implanted device, the facility should not receive 300 percent of the device cost. The commenter noted, however, that the device portion of the Medicare fee represents a median cost, not necessarily the true cost of a device used in any given procedure. The commenter provided an example using CPT code 63685, where Medicare calculated the average cost of the implanted neurostimulator was $15,353 but,

depending on whether a rechargeable or non-rechargeable neurostimulator is used, the actual price of the device can vary between $13,382 and $19,505. The commenter recommended that the Department use the non-device portion of the Medicare fee to establish the PIP fee and have the device reimbursed separately at invoice plus 20 percent.

RESPONSE: The Department was not aware that the device price on the Medicare fee was a median price. The Department will investigate this and, if it is correct, the Department agrees that it might be more appropriate in future revisions to the fee schedule to have the device reimbursed separately from the fee for the procedure to insert it. However, such a change cannot be made on adoption because it would constitute a substantial change requiring additional notice and public comment. The Department notes that the portion of the fee for the insertion of the device is set at 300 percent of Medicare, which should offset some of the differences in cost of different types of devices.

COMMENT: One commenter stated that it could not duplicate the Department's calculation of the HOSF fees for device intensive procedures. The commenter gave an example using CPT 63685 for the northern New Jersey region: the device portion of the fee for this service is $12,623 of the Medicare total fee of $17,505 resulting in a fee of $4,882 for the procedure. The calculation of the ASC fee would be: $4,882 x 3.0 = $14,646 (facility portion) plus $12,623 x 1.2 = $15,147 (120 percent of device cost) = a total fee of $29,793. However, the Department's calculation for this fee was $23,191.

RESPONSE: The Department does not agree with the numbers used by the commenter. For CPT 63685, the Department used the National 2011 Hospital Outpatient APC

payment amount of $14,743.58, subtracted the device portion of $12,738.45 and multiplied the remainder, $2,005.13, times the wage index for Bergen County of 1.3142. The resulting amount, $2635.14846, was multiplied by 3.0 and added to the device portion times 1.2, which equaled $15,286.14. The grand total was $23,191.56.

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

COMMENT: Several commenters noted that the Department stated in the Summary of the notice of proposed substantial changes that the fees on the Hospital Outpatient Surgical Facility Fee Schedule were 35 percent higher than those on the Ambulatory Surgical Center Fee Schedule. The commenters included calculations that showed that the fees on the HOSF schedule ranged between 90 and 104 percent higher than the fees on the ASC fee schedule for the same CPT codes. Several commenters stated that if different fees for ASCs and hospital outpatient facilities were necessary, the way to do that was to lower the fees paid to ASCs.

RESPONSE: The 35 percent figure in the Summary to the notice of proposed substantial changes on adoption referred to the difference between the national Ambulatory Payment Classification amount for each service as set by CMS and the ASC fee schedule amount and did not include the local wage adjustment percentages, which, as the commenter noted, increases the percent difference between the ASC and HOSF fees. However, both fee schedules are calculated at 300 percent of Medicare.

COMMENT: One commenter questioned whether the Department made an error in its calculation of the HOSF schedule. The commenter noted that the CMS wage indices for Bergen and Atlantic counties are very similar and questioned why the fees for one code, CPT 64483, were different percentages of the ASC fee schedule: 49 percent and 53

percent for the north and south regions, respectively. The commenter also questioned why the fees for CPT 64418 was 29 and 31 percent of the ASC fee schedule for the north and south regions while, as noted above, the same percentages for CPT 64483 were higher.

RESPONSE: The Department does not agree with the commenter. The Department used a hospital-adjusted wage index of 1.1264 percent in the Southern Region, not the 1.0822 percent used by the commenter.

COMMENT: One commenter stated that it disagreed with the Department's proposal to make the fee for CDT D7880 equal to the fees for CPT codes 21085 and 21110. The commenter noted that D7880 was a code for a simple occlusal device for the treatment of TMJ. The commenter recommended that the Department clarify the use of each code.

RESPONSE: The Department does not agree with the commenter. A search on the PIP Arbitration administrator's website of arbitration decisions reveals a number of cases where the dispute was whether CDT 7880 or CPT 21110 were the correct codes. Making the fees for all three of these similar codes the same will reimburse providers slightly more for cases where D7880 is the correct code but this increase will be offset by eliminating disputes about the correct code from arbitrations.

COMMENT: One commenter stated that it supported the proper use of discography to determine the cause of pain and urged the Department to reinstate 62290, 62291, 72285, and 77295 on the Physicians', ASC, and HOSP Fee Schedules.

RESPONSE: The Department does not believe that removal of the CPT codes listed by the commenter has any relation to the proper use of discography. As noted above in

response to other Comments, the restriction on procedures that can be performed in an ASC is the implementation of the Department's statutory obligation to determine the appropriateness of treatment and it is based upon CMS's comprehensive national standards for patient safety in ASCs.

COMMENT: One commenter stated that it supported the use of diagnostic hip and sacroiliac joint injections and urged the Department to place the corresponding codes on the ASC list.

RESPONSE: The Department notes that the commenter did not provide a CPT code(s) for the procedures that it wishes to include onto the fee schedule. Without such a code(s), the Department cannot determine if the procedure can be performed in an ASC. In addition, such a change would be a substantial change upon adoption requiring additional notice and opportunity to comment.

COMMENT: One commenter stated appeals in the current rule where each insurer has its own appeal process that varies in scope, scale, dates of implementation, information, signatures, forms, levels, and what must be appealed is causing providers to no longer accept PIP patients. The commenter urged the Department to establish a uniform appeal process.

RESPONSE: The comment is outside the scope of the notice of proposed substantial changes The Department notes that the August 1, 2011 proposal contains provisions for a uniform appeal process and refers the commenter to previous comments addressing the Department's intentions for establishing a uniform internal appeals procedure.

COMMENT: One commenter stated that Intradiscal Electrothermal Anuloplasty (IDET)

is a reasonable treatment for patients. The commenter noted that there is no fee for it in the ASC or HOPD fee schedules. The commenter requested that the Department provide an ASC and HOSF fee for CPT codes 22526 and 22527.

RESPONSE: The Department does not believe that removal of the CPT codes listed by the commenter has any relation to the proper use of IDET. As noted above in response to other Comments, the restriction on procedures that can be performed in an ASC is the implementation of the Department's statutory obligation to determine the appropriateness of treatment and it is based upon CMS's comprehensive national standards for patient safety in ASCs.

Agency Note: A number of commenters submitted the same comment on the notice of proposed substantial changes as was submitted to the original proposal. The summary and responses to these comments can be found in the section of this adoption notice that includes the comments and responses to the original proposal. Several commenters complained that their names were not listed in the notice of proposed substantial changes even though they made comments on the parts of the proposal that were proposed for amendment in the notice of proposed substantial changes. The Department regrets the omissions. All the comments were reviewed prior to the publication of the notice of proposed substantial changes. The Department has filed a complete list of the names of all parties who submitted comments on the initial proposal at the Office of Administrative Law.

Federal Standards Statement

A Federal standards analysis is not required because the adopted new rules, amendments, and repeals 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**]*):

SUBCHAPTER 4. PERSONAL INJURY PROTECTION BENEFITS; MEDICAL PROTOCOLS; DIAGNOSTIC TESTS

11:3-4.2 Definitions

The following words, phrases and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Days" means calendar days unless specifically designated as business days.

1. A calendar and business day both end at the time of the close of business hours**. Insurers shall set a close of business time in their Decision Point Review plans***;

2. - 3. (No change from proposal.)

…

["WCMCO" means a workers' compensation managed care organization approved pursuant to N.J.A.C. 11:6.]

…

11:3-4.4 Deductibles and co-pays

(a) - (c) (No change.)

(d) An insurer may file policy language that waives the co-payment and deductible in (a) and (b) above when the insured receives medical treatment from a provider that is part of

an ODS *[or a WCMCO network]* that has contracted with the insurer or its PIP vendor. The insured shall not be required to elect to use the providers or facilities in such an ODS *[or a WCMCO network]* either at issuance of the policy or when the claim is made.

1. Upon receipt of notification of a claim, the insurer or its PIP vendor shall make available to the insured information about physicians and facilities in any ODS *[or WCMCO network]* with which it has a contract.

i. The information shall include a notice that the insured is not required to use the providers or facilities of an ODS *[or a WCMCO network]* with which the insurer or its PIP vendor has contracted and indicate that if the insured chooses to receive covered services from such providers or facilities, the deductible and copayments in (a) and (b) above would not apply.

ii. The information shall also indicate that the insured may seek treatment from providers and facilities that are not part of an ODS *[or WCMCO network]* with which the insurer or its PIP vendor has contracted, in which case the deductible and copayments in (a) and (b) above would apply.

2. The actual ODS *[or WCMCO network]* access fee or 25 percent of the reduction in charges resulting from the use of the ODS *****[or WCMCO network**]*** provider, whichever is less, may be included within the policy limits for any single bill from an in-network provider in the ODS *[or WCMCO network]* with billed charges of $10,000 or more.

Example: A $10,000 charge is reduced by the ODS *[or WCMCO network]* contract with the insurer by 45 percent to $5,500. The insurer could include the ODS *****[or

WCMCO network]***** access fee or $1,125 (25 percent of the $4,500 reduction), whichever is less, within the policy limits.

(e) - (i) (No change.)

11:3-4.7A PIP vendor registration requirements

(a) (No change from proposal.)

(b) Any PIP vendor working for an insurer prior to *[the effective date of this rule]* ***November 5, 2012*** shall file for registration *[within 90 days of the effective date of this rule]* ***by February 3, 2013***.

(c) – (k) (No change from proposal.)

(l) All data or information in the PIP vendor's application for registration ***and the vendor's contract with the insurer required to be submitted pursuant to N.J.A.C. 11:3-4.7(c)1*** shall be confidential and shall not be disclosed to the public, except as follows:

1. – 4. (No change from proposal.)

(m) (No change from proposal.)

11:3-4.9 Assignment of benefits; public information

(a) Pursuant to N.J.S.A. 39:6A-4, an insured may only assign benefits and duties under the policy to a provider of *[medical expense]* ***service*** benefits. Insurers may file for approval policy forms that include reasonable procedures for restrictions on the

assignment of personal injury protection benefits and duties under the policy, consistent with the efficient administration of the coverage and the prevention of fraud. Insurers may not prohibit the assignment of benefits to providers. Reasonable restrictions may include, but are not limited to:

1. A requirement that as a condition of assignment, the provider agrees to follow the requirements of the insurer's decision point review plan for making decision point review and precertification requests; *[and/or]*

2. A requirement that as a condition of assignment, the provider shall hold the insured harmless for penalty co-payments imposed by the insurer based on the provider's failure to follow the requirements of the insurer's *[Decision Point Review Plan]* ***decision point review plan*; and/or**

3. A requirement that as a condition of assignment, the provider agrees to submit disputes to alternate dispute resolution pursuant to N.J.A.C. 11:3-5.*

(b) - (c) (No change from proposal.)

SUBCHAPTER 5. PERSONAL INJURY PROTECTION DISPUTE RESOLUTION

11:3-5.6 Conduct of PIP dispute resolution proceedings

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

(f) The award shall be signed by the dispute resolution professional. The original shall be filed with the administrator, and copies provided to each party. If the award requires payment by the insurer for a treatment or test, payment shall be made together with any accrued interest ordered in the award pursuant to N.J.S.A. 39:6A-5, within 45

days of the insurer's receipt of a copy of the determination, unless *[an action has been filed in the Superior Court pursuant to N.J.S.A. 2A:23A-13 as]*** *one of the actions*** permitted in (g) below ***has been filed****.** Where the arbitration has been filed by a provider who is the assignee of benefits pursuant to N.J.A.C. 11:3-4.7B, the payment shall be made payable to the provider.

(g) (No change from proposal.)

11:3-5.12 Prohibition of conflicts of interest

(a) - (e) (No change.)

*****[(f) For one year after the termination of professional services of any dispute resolution professional, he or she shall not appear before any dispute resolution professional representing claimants or respondents.**]***

SUBCHAPTER 29. MEDICAL FEE SCHEDULES: AUTOMOBILE INSURANCE PERSONAL INJURY PROTECTION AND MOTOR BUS MEDICAL EXPENSE INSURANCE COVERAGE

11:3-29.1 Purpose and scope

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

(d) This subchapter does not apply to the following:

1. – 3. (No change.)

4. Inpatient services provided by acute care hospitals, trauma centers, rehabilitation facilities, other specialized hospitals, residential alcohol treatment facilities and nursing homes**,** except as specifically set forth in this subchapter. *[Non-emergency

outpatient services on the fee schedules including those provided by the above facilities, are subject to this subchapter.]*

11:3-29.2 Definitions

The following words, phrases and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

. . .

"Ambulatory surgical case" means a procedure that is not minor surgery as defined in N.J.A.C. 13:35-4A.3.

. . .

"Hospital" means a general acute care hospital, a long-term acute care hospital or a comprehensive rehabilitation hospital.

. . .

"Hospital outpatient surgical facility" or "HOSF" means a facility where hospital outpatients are treated.

. . .

["Outpatient surgical facility" or "OSF" means an ASC, a doctor's office where ambulatory surgical cases are performed or a facility where non-emergency hospital outpatients are treated.]

. . .

11:3-29.4 Application of medical fee schedules

(a) Nothing in this subchapter shall 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**. *Insurers are not required to pay for services or equipment that are not medically necessary.**

1.* The ***fees for*** physicians' *[fee schedule at]* ***services in*** subchapter Appendix, Exhibit 1**,***[and]* the provisions in (f)***1 through 7*** below ***and the non-physician facility fees in subchapter Appendix, Exhibit 7*** shall not apply to trauma services at Level I and Level II trauma hospitals. Bills for services subject to the trauma services exemption shall use the modifier "–TS".

***2. The non-physician facility fees in subchapter Appendix, Exhibit 7 shall not apply to services provided in hospital emergency rooms. The bills for these services shall use the modifier "-ER".**

3. The physician fees for* *[Surgical]* ***surgical*** services (CPT 10000 though 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]****s'*** fee***s* *[**schedule and]* ***in subchapter Appendix, Exhibit 1. The bills for these services*** shall use the modifier "-ER". *[Insurers are not required to pay for services or equipment that are not medically necessary.]*

4. Except as provided in (a)1 through 3 above, the fees in Appendix, Exhibits 1 through 7 apply regardless of the site of service.

(b) – (d) (No change from proposal.)

(e) Except as noted in (e)1*[and 2]* ***through 3*** 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. When a CPT, CDT or HCPCS code for the service performed has been changed since the fee schedule rule was last amended, the provider shall always bill the actual and correct code found in the most recent version of the American Medical Association's Current Procedural Terminology or the American Dental Association's Current Dental Terminology. The amount that the insurer pays for the service shall be in accordance with this subsection. 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. - 2. (No change from proposal.)

3. Codes in Appendix, Exhibit 1 that do not have an amount in the ASC facility fee column are not reimbursable if performed in an ASC and are not subject to the provision in (e) above concerning services not set forth in or covered by the fee schedules.

(f) (No change from proposal.)

(g**)** Except as specifically stated to the contrary in this subchapter, the fee schedules shall be interpreted in accordance with the following, incorporated herein by reference, as amended and supplemented: the relevant chapters of the Medicare Claims Processing Manual, updated periodically by CMS, that were in effect at the time the service was provided. The Medicare Claims Processing Manual is available at https://www.cms.gov/Manuals/IOM/itemdetail.asp?itemID=CMS018912; the NCCI Policy Manual for Medicare Services, as updated periodically by CMS and available at http://www.cms.gov/NationalCorrectCodInitEd/Downloads/NCCI_Policy_Manual.zip; Modifier 59 Article: Proper Usage Regarding Distinct Procedural Service, available from CMS at https://www.cms.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf; and the CPT Assistant available from the American Medical Association (www.AMAbookstore.com).

1. – 2. (No change from proposal.)

3. X-ray digitization or computer aided radiographic mensuration reported under CPT 76499 or any other code are not *[reimburseable]* ***reimbursable*** under PIP.

4. (No change from proposal.)

5. Platelet Rich Plasma (PRP) injections are only *[reimburseable]* ***reimbursable*** for treatment of chronically injured tendons that have failed to improve despite appropriate conservative treatments. PRP injections shall be billed under code 0232T in subchapter Appendix, Exhibit 1

6. Leads, pads, batteries and any other supplies for use of TENS or EMS devices are included in the fee for the rental *[or purchase]* of the unit and are not separately *[reimburseable]* ***reimbursable when rented***. ***For purchase of the unit, the first month's supply of leads, pads, batteries and any other supplies for TENS or EMS units are included.***

7. The eligible charge for an office visit includes reviewing the report of an imaging study when the provider of the imaging study has billed for the technical and professional component of the service. In these circumstances, it is not appropriate for the provider to bill for an office visit, CPT 76140 or for the physician component of the imaging study. CPT 76140 is not *[reimburseable]* ***reimbursable***. Where a provider in a different practice or facility *[makes]* ***performs*** a medically necessary review*[s]* ***of*** an imaging study and produces a written report as part of a consultation, the provider shall bill the professional component (modifier -26) for each specific radiology service.

8. – 10. (No change from proposal.)

11. Moderate (conscious) sedation performed by the physician who also furnishes the medical or surgical service cannot be reimbursed separately for the procedures listed in Appendix G of the CPT manual. In that case, payment for the sedation is bundled into the payment for the medical or surgical service. As a result, CPT codes 99143 through 99145 are not *[reimburseable]* ***reimbursable*** for the procedures in Appendix G of the CPT manual.

12 – 13. (No change from proposal.)

(h) - (p) (No change from proposal.)

11:3-29.5 *[Outpatient surgical facility fees]* ***ASC facility fees**; **hospital outpatient surgical facility fees***

(a) *[Outpatient surgical]* ***ASC*** facility fees are listed *[on the Physicians' Fee Schedule]* ***in Appendix, Exhibit 1,*** by CPT code. *[The outpatient surgical facility fee is the maximum that can be reimbursed for outpatient procedures regardless of whether they are performed in a hospital outpatient facility, an ASC or a physicians' office.]* Codes *[on the Physicians' Fee Schedule]* that do not have an amount in the *[outpatient surgical]* ***ASC*** facility ***fee*** column *[cannot be performed in such facilities]* ***are not reimbursable if performed in an ASC***. The ***[outpatient surgical]* ***ASC*** facility fee***s*** include*[s]* services that would be covered if the services were furnished in a hospital on an inpatient or outpatient basis, including:

1. – 3. (No change from proposal.)

4. Diagnostic and therapeutic items and services*[,]****.*** Appendix, Exhibit 1*[, the Physicians' Fee Schedule]* indicates those CPT codes that, according to Medicare (see: www.cms.gov/ASCPayment/ASCRN/list.asp, CMS-1504-FC, Exhibit AA) are considered ancillary services that are integral to surgical procedures and are not permitted to be reimbursed separately ***in an ASC. Appendix, Exhibit 7 indicates those services that, according to Medicare (see: https://www.cms.gov/HospitalOutpatientPPS/Downloads/CMS1506FC_Addendum_D1.pdf) are considered ancillary services to surgical procedures and are not permitted to be reimbursed separately in a HOSF***;

5. (No change from proposal.)

6. Blood, blood plasma, platelets, etc.; *[and]*

7. Anesthesia materials, including the anesthetic itself, and any materials, whether disposable or re-usable, necessary for its administration*[.]***; and**

8. Implantable DME and prosthetics.*

(b) HOSF fees are listed on subchapter Appendix, Exhibit 7 by CPT code. The hospital outpatient surgical facility fee is the maximum that can be reimbursed for outpatient procedures performed in an HOSF. The hospital outpatient facility fees in Appendix Exhibit 7 include services that would be covered if furnished in a hospital on an inpatient basis, including those set forth in (a)1 through 8 above.

[(b)] ***(c)*** *[The following services are not included in the outpatient surgical facility fee:

1.]* The sale, lease or rental of durable medical equipment (DME) to patients for use in their homes ***are not included in the ASC or HOSF fee.*** If the *[outpatient surgical facility]* ***ASC or HOSF*** furnishes items of DME to patients, billing for such items should be made in accordance with subchapter Appendix, Exhibit 5***.***[; and

2. Prosthetic and other devices must be billed in accordance with N.J.A.C. 11:3-29.4(f)8.]*

[(c)] ***(d)*** When multiple procedures are performed in an ***[**outpatient surgical facility]* ***ASC or in an HOSF*** in the same operative session, the ***[**outpatient surgical]* ***ASC*** facility fee ***or the HOSF fee, as applicable,*** for the procedure with the highest payment amount is reimbursed at 100 percent and reimbursement of any additional procedures furnished in the same session is 50 percent of the applicable facility fee.

1. (No change from proposal.)

2. Subchapter ***[**Appendix]* ***Appendices,*** Exhibit 1, the Physicians' and *[Outpatient Surgical]* ***ASC*** Facility Fee Schedule ***and Exhibit 7, the HOSF fee schedule***, indicate*[s]* those CPT codes that, according to Medicare (see: www.cms.gov/ASCPayment/ASCRN/list.asp ***and http://www.cms.gov/HospitalOutpatientPPS/)*** are exempt from the multiple procedure reduction formula.

11:3-*[29.5]****29.6*** (No change in text.)

(**Office of Administrative Law Note:** The text of new N.J.A.C. 11:3-29 Appendix, Exhibit 7, included as a substantial change, does not appear in boldface with asterisks as boldface is used within the Exhibit text.)

APPENDIX

(Insert Appendix, Exhibits 1 and 2 from the proposal, showing the changes upon adoption in the adopted Exhibits 1 and 2 accompanying this notice; Appendix Exhibits 3, 4, 5, and 6 from the proposal; and adopted Appendix, Exhibit 7 accompanying this notice.)

APPENDIX

Exhibit 1

Physicians' & *[Outpatient]* ***Ambulatory*** Surgical ***Center (ASC)*** Facility Fee Schedule

CPT* HCPCS	MOD	DESCRIPTION	Physicians' Fees North	Physicians' Fees South		*[Outpatient Surgical Facility]* *ASC* Fees North	*[Outpatient Surgical Facility]* *ASC* Fees South	Payment Indicator (See bottom for codes)
. . .								
[20660]		*[APPLY, REM FIXATION DEVICE]*	*[381.89]*	*[369.85]*				
[20661]		*[APPLY HEAD BRACE]*	*[779.55]*	*[745.80]*				
. . .								
[20664]		*[HALO BRACE APPLY]*	*[1,287.51]*	*[1,238.22]*				
20665		REMOVE FIXATION DEVICE	*[175.48]*	*[167.39]*		89.55	82.44	X
20670		REMOVE SUPPORT IMPLANT	*[637.48]*	*[600.09]*		2,411.70	2,219.85	
. . .								
[20937]		*[SP BONE ALLOGRAFT MORSEL, ADDED]*	*[720.93]*	*[697.25]*				
[20938]		*[SP BONE ALLOGRAFT STRUCT, ADDED]*	*[790.60]*	*[765.16]*				
. . .								
21085		PREPARE FACE/ORAL PROSTHESIS	*[1,260.46]* ***1,453.19***	*[1,209.45]* ***1,375.54***		1,265.82	1,165.11	
. . .								
[22220]		*[REVISE NECK SPINE]*	*[6,818.79]*	*[6,572.06]*				
[22222]		*[REVISE THORAX SPINE]*	*[6,314.11]*	*[6,084.66]*				
[22224]		*[REVISE LUMBAR SPINE]*	*[6,684.27]*	*[6,437.76]*				
[22226]		*[REVISE, EXTRA SPINE SEGMENT]*	*[1,568.66]*	*[1,517.81]*				
22305		TREAT SPINE PROCESS FX	*[799.90]*	*[764.05]*		210.60	193.83	
22310		TREAT SPINE FX	*[1,269.31]*	*[1,216.97]*		734.37	675.96	
. . .								
[22318]		*[TREAT ODONTOID FX W/O GRAFT]*	*[6,900.86]*	*[6,658.98]*				
[22319]		*[TREAT ODONTOID FX W/GRAFT]*	*[7,677.12]*	*[7,413.74]*				
[22325]		*[TREAT SPINE FX]*	*[6,047.90]*	*[5,825.87]*				
[22326]		*[TREAT NECK SPINE FX]*	*[6,272.10]*	*[6,047.13]*				
[22327]		*[TREAT THORAX SPINE FX]*	*[6,237.86]*	*[6,008.33]*				
[22328]		*[TREAT EACH ADDED SPINE FX]*	*[1,212.38]*	*[1,173.97]*				
. . .								
22520		PERCUT VERTEBROPLASTY THORACIC	*[10,083.82]*	*[9,477.17]*		4,301.40	3,959.25	
22521		PERCUT VERTEBROPLASTY LUMBAR	*[9,901.74]*	*[9,303.09]*		4,301.40	3,959.25	
22522		PERCUT VERTEBROPLASTY ADDED	*[970.35]*	*[938.55]*		4,301.40	3,959.25	
[22526]		*[IDET, SINGLE LEVEL]*	*[6,633.00]*	*[4,210.00]*				
[22527]		*[IDET, 1 OR MORE LEVELS]*	*[5,369.00]*	*[3,408.00]*				
[22532]		*[LAT THORAX SPINE FUSION]*	*[8,628.72]*	*[8,325.88]*				
[22533]		*[LAT LUMBAR SPINE FUSION]*	*[8,136.28]*	*[7,844.68]*				
[22534]		*[LAT THOR/LUMBAR, ADDED SEGMENT]*	*[1,780.94]*	*[1,723.44]*				
[22548]		*[NECK SPINE FUSION]*	*[9,410.36]*	*[9,086.14]*				

[22551]		*[NECK SPINE FUSE & REMOVE ADDL]*	*[8,441.88]*	*[8,144.16]*				
[22552]		*[ADDED NECK SPINE FUSION]*	*[1,951.91]*	*[1,888.77]*				
. . .								
[22556]		*[THORAX SPINE FUSION]*	*[8,088.76]*	*[7,802.40]*				
[22558]		*[LUMBAR SPINE FUSION]*	*[7,467.81]*	*[7,203.88]*				
. . .								
[22590]		*[SPINE & SKULL SPINAL FUSION]*	*[7,625.26]*	*[7,352.42]*				
[22595]		*[NECK SPINE FUSION]*	*[7,251.72]*	*[6,990.41]*				
[22600]		*[NECK SPINE FUSION]*	*[6,203.61]*	*[5,974.93]*				
[22610]		*[THORAX SPINE FUSION]*	*[6079.04]*	*[5852.85]*				
[22612]		*[LUMBAR SPINE FUSION]*	*[7,743.54]*	*[7,467.24]*				
[22614]		*[SPINE FUSION, EXTRA SEGMENT]*	*[1,925.02]*	*[1,863.10]*				
[22630]		*[LUMBAR SPINE FUSION]*	*[7,469.56]*	*[7,201.26]*				
[22632]		*[SPINE FUSION, EXTRA SEGMENT]*	*[1,569.27]*	*[1,519.25]*				
[22800]		*[FUSE SPINE]*	*[6,570.03]*	*[6,327.97]*				
[22802]		*[FUSE SPINE]*	*[10,255.53]*	*[9,888.76]*				
[22804]		*[FUSE SPINE]*	*[11,812.16]*	*[11,392.31]*				
[22808]		*[FUSE SPINE]*	*[8,911.23]*	*[8,597.59]*				
[22810]		*[FUSE SPINE]*	*[9,894.23]*	*[9,551.68]*				
[22812]		*[FUSE SPINE]*	*[10,726.06]*	*[10,335.64]*				
[22830]		*[EXPLORE SPINAL FUSION]*	*[3,925.16]*	*[3,777.02]*				
[22840]		*[INSERT SPINE FIXATION DEVICE]*	*[4,687.17]*	*[4,536.75]*				
[22842]		*[INSERT SPINE FIXATION DEVICE]*	*[4,695.97]*	*[4,544.73]*				
[22843]		*[INSERT SPINE FIXATION DEVICE]*	*[4,987.18]*	*[4,825.50]*				
[22844]		*[INSERT SPINE FIXATION DEVICE]*	*[6,027.85]*	*[5,826.82]*				
. . .								
[22846]		*[INSERT SPINE FIXATION DEVICE]*	*[4,688.15]*	*[4,540.41]*				
[22847]		*[INSERT SPINE FIXATION DEVICE]*	*[5,354.75]*	*[5,191.05]*				
[22848]		*[INSERT PELVIC FIXATION DEVICE]*	*[2,208.58]]*	*[2,135.18]*				
[22849]		*[REINSERT SPINAL FIXATION]*	*[7,902.75]*	*[7,621.10]*				
[22850]		*[REMOVE SPINE FIXATION DEVICE]*	*[4,360.21]*	*[4,194.71]*				
. . .								
[22852]		*[REMOVE SPINE FIXATION DEVICE]*	*[4,169.67]*	*[4,010.02]*				
[22855]		*[REMOVE SPINE FIXATION DEVICE]*	*[6,775.56]*	*[6,533.32]*				
[22856]		*[CERV ARTIFICIAL DISKECTOMY]*	*[10,046.89]*	*[9,695.88]*				
[22857]		*[LUMBAR ARTIFICIAL DISKECTOMY]*	*[10,139.75]*	*[9,791.25]*				
. . .								
27096		INJECT SACROILIAC JOINT	586.47	554.47		***1,012.32***	***931.80***	
. . .								
33210		INSERT HEART ELECTRODE	297.55	288.11		*[6,965.49]* ***3,763.15***	*[6,411.39]* ***3,209.05***	
33212		INSERT PULSE GENERATOR	564.31	544.12		*[19,984.50]* ***11,119.83***	*[18394.77]* ***9,530.10***	
. . .								

36558		INSERT TUNNELED CV CATH	1,353.89	1,277.30		*[3,424.68]* ***2,289.41***	*[3,152.28]* ***2,017.01***	
. . .								
36571		INSERT PICVAD CATH	2,151.26	2,023.38		*[3,424.68]* ***2,289.41***	*[3,152.28]* ***2,017.01***	
. . .								
36578		REPLACE TUNNELED CV CATH	855.29	808.35		*[3,424.68]* ***2,289.41***	*[3,152.28]* ***2,017.01***	
. . .								
36800		INSERT CANNULA	261.61	251.45		*[4,680.63]* ***4,009.88***	*[4,308.30]* ***3,637.55***	
36810		INSERT CANNULA	340.24	329.61		*[4,680.63]* ***4,009.88***	*[4,308.30]* ***3,637.55***	
36815		INSERT CANNULA	244.77	236.68		*[4,680.63]* ***4,009.88***	*[4,308.30]* ***3,637.55***	
. . .								
37204		TRANSCATHETER OCCLUSION	1,460.69	1,414.57		*[12,369.78]* ***8,466.97***	*[11,385.78]* ***7,482.97***	
. . .								
49421		INSERT ABDOM DRAIN, PERM	425.09	409.71		*[4,135.62]* ***3,521.06***	*[3,806.64]* ***3,192.08***	
. . .								
[61154]		*[PIERCE SKULL & REMOVE CLOT]*	*[4,585.38]*	*[4,422.79]*				
[61312]		*[OPEN SKULL FOR DRAIN]*	*[12,568.27]*	*[12,152.49]*				
[61313]		*[OPEN SKULL FOR DRAIN]*	*[11,978.90]*	*[11,573.02]*				
61790		TREAT TRIGEMINAL NERVE	*[1,360.46]*	*[1,311.64]*		2,552.34	2,349.30	
. . .								
62350		IMPLANT SPINAL CANAL CATH	*[1,421.73]*	*[1,368.80]*		5,591.79	5,146.98	
62355		REMOVE SPINAL CANAL CATHETER	*[1,078.08]*	*[1,036.07]*		1,706.88	1,571.10	
62360		INSERT SPINE INFUSION DEVICE	*[1,101.95]*	*[1,059.35]*		5,591.79	5,146.98	
62362		IMPLANT SPINE INFUSION PUMP	*[1,485.61]*	*[1,430.02]*		*[42,080.97]* ***22,241.41***	*[38,733.54]* ***18,893.98***	
62365		REMOVE SPINE INFUSION DEVICE	*[1,188.99]*	*[1,142.45]*		4,972.53	4,576.98	
62367		ANALYZE SPINE INFUSION PUMP	*[149.54]*	*[142.62]*		76.02	69.99	X
62368		ANALYZE SPINE INFUSION PUMP	*[214.47]*	*[204.87]*		102.96	94.77	X
[63020]		*[NECK SPINE DISK SURG]*	*[8,480.91]*	*[8,175.53]*				
[63030]		*[LOW BACK DISK SURG]*	*[7,039.21]*	*[6,777.38]*				
[63035]		*[SPINAL DISK SURG, ADDED]*	*[1,413.89]*	*[1,368.63]*				
[63040]		*[LAMINOTOMY, SINGLE CERV]*	*[10,204.24]*	*[9,848.95]*				
[63042]		*[LAMINOTOMY, SINGLE LUMBAR]*	*[9,460.80]*	*[9,120.66]*				
[63043]		*[LAMINOTOMY, ADDED CERV]*	*[2,199.31]*	*[2,122.51]*				
[63044]		*[LAMINOTOMY, ADDED LUMBAR]*	*[2,212.36]*	*[2,135.10]*				
[63045]		*[REMOVE SPINAL LAMINA]*	*[9,234.32]*	*[8,908.87]*				
[63046]		*[REMOVE SPINAL LAMINA]*	*[8,797.11]*	*[8,483.60]*				
[63047]		*[REMOVE SPINAL LAMINA]*	*[8,004.21]*	*[7,710.97]*				
[63048]		*[REMOVE SPINAL LAMINA,	*[1,563.04]*	*[1,513.45]*				

		ADDED]*						
[63050]		*[CERV LAMINOPLASTY]*	*[11,407.20]*	*[11,016.69]*				
[63051]		*[CERV LAMINOPLASTY W/GRAFT/PLATE]*	*[12,463.89]*	*[12,031.08]*				
[63056]		*[DECOMPRESS SPINAL CORD]*	*[10,760.37]*	*[10,383.89]*				
[63057]		*[DECOMPRESS SPINE CORD, ADDED]*	*[2,363.35]*	*[2,288.12]*				
. . .								
[63077]		*[SPINE DISK SURG, THORAX]*	*[10,914.43]*	*[10,533.96]*				
[63078]		*[SPINE DISK SURG, THORAX]*	*[1,426.61]*	*[1,379.85]*				
[63081]		*[REMOVE VERTEBRAL BODY]*	*[12,892.45]*	*[12,447.96]*				
[63082]		*[REMOVE VERTEBRAL BODY, ADDED]*	*[1,975.19]*	*[1,912.82]*				
63650		IMPLANT NEUROELECTRODES	*[3,014.38]*	*[2,903.40]*		*[12,765.69]* ***7,941.86***	*[11,750.22]* ***6,926.39***	X
63655		IMPLANT NEUROELECTRODES	*[6,263.82]*	*[6,031.77]*		*[17,986.41]* ***10,702.41***	*[16,555.65]* ***9,271.65***	X
63685		INSERT/REDO SPINE N GENERATOR	*[2,895.73]*	*[2,787.18]*		*[47,572.08]* ***24,642.86***	*[43,787.88]* ***20,858.66***	X
63688		REVISE/REMOVE NEURORECEIVER	*[2,623.21]*	*[2,523.05]*		3,880.14	3,571.47	
64400		NERVE BLOCK INJ, TRIGEMINAL	*[282.90]*	*[269.04]*		237.48	218.58	
. . .								
64412		NERVE BLOCK INJ, SPINAL ACCESSORY	*[377.77]*	*[357.92]*		352.14	324.12	
64430		NERVE BLOCK INJ, PUDENDAL	*[358.09]*	*[340.29]*		1,012.32	931.80	
. . .								
64446		NERVE BLOCK INJ, SCIATIC, CONT INF	*[195.50]*	*[189.92]*		1,012.32	931.80	
. . .								
64448		NERVE BLOCK INJ, FEM, CONT INF	*[173.59]*	*[168.69]*		1,012.32	931.80	
. . .								
64455		NERVE BLOCK INJ, PLANTAR DIGIT	*[119.59]*	*[114.82]*		71.37	65.70	
. . .								
64490		INJECT PARAVERT F JNT C/T 1 LEV	***494.93***	***469.59***		1,012.32	931.80	
64491		INJECT PARAVERT F JNT C/T 2 LEV	***241.80***	***230.50***		355.95	327.66	
64492		INJECT PARAVERT F JNT C/T 3 LEV	***244.49***	***233.01***		355.95	327.66	
64493		INJECT PARAVERT F JNT L/S 1 LEV	***442.52***	***419.26***		1,012.32	931.80	
64494		INJECT PARAVERT F JNT L/S 2 LEV	***218.85***	***208.33***		355.95	327.66	
64495		INJECT PARAVERT F JNT L/S 3 LEV	***222.43***	***211.68***		355.95	327.66	
. . .								
64555		IMPLANT NEUROELECTRODES	*[325.74]*	*[310.44]*		*[12,765.69]* ***7,941.86***	*[11,750.22]* ***6,926.39***	X
64561		IMPLANT NEUROELECTRODES	*[1,613.98]*	*[1,525.77]*		*[12,765.69]* ***7,941.86***	*[11,750.22]* ***6,926.39***	X
64565		IMPLANT NEUROELECTRODES	286.59	272.61		*[12,765.69]* ***7,941.86***	*[11,750.22]* ***6,926.39***	X

. . .								
64702		REVISE FINGER/TOE NERVE	*[767.00]*	*[734.49]*		2,552.34	2,349.30	
64704		REVISE HAND/FOOT NERVE	*[512.39]*	*[491.31]*		2,552.34	2,349.30	
64708		REVISE ARM/LEG NERVE	*[1,180.59]*	*[1,131.42]*		2,552.34	2,349.30	
64712		REVISE SCIATIC NERVE	*[1,335.75]*	*[1,283.50]*		2,552.34	2,349.30	
64713		REVISE ARM NERVE(S)	*[1,840.45]*	*[1,772.26]*		2,552.34	2,349.30	
64714		REVISE LOW BACK NERVE(S)	*[1,625.15]*	*[1,564.83]*		2,552.34	2,349.30	
64716		REVISE CRANIAL NERVE	*[1,304.40]*	*[1,249.13]*		2,552.34	2,349.30	
64718		REVISE ULNAR NERVE AT ELBOW	*[1,425.15]*	*[1,364.68]*		2,552.34	2,349.30	
64719		REVISE ULNAR NERVE AT WRIST	*[965.88]*	*[924.67]*		2,552.34	2,349.30	
. . .								
95805	***26***	***MULTIPLE SLEEP LATENCY TEST***	***96.75***	***93.32***				
. . .								
95812	***TC***	***EEG, 41-60 MINUTES***	***447.02***	***417.10***				
95812	***26***	***EEG, 41-60 MINUTES***	***84.26***	***81.37***				
95813		***EEG, OVER 1 HOUR***	***594.86***	***559.52***				
. . .								
[98505]	*[26]*	*[MULTIPLE SLEEP LATENCY TEST]*	*[96.75]*	*[93.32]*				
[98512]	*[TC]*	*[EEG, 41-60 MINUTES]*	*[447.02]*	*[417.10]*				
[98512]	*[26]*	*[EEG, 41-60 MINUTES]*	*[84.26]*	*[81.37]*				
[98513]		*[EEG, OVER 1 HOUR]*	*[594.86]*	*[559.52]*				
. . .								
98943		***CHIROPRACTIC MANIP TX; XTRASPINAL 1/MORE REGIONS***	***37.14***	***36.01***				
. . .								
N1 = *[OSF]* ***ASC*** Packaged Procedure no separate payment								
X = *[OSF* ***ASC*** Codes Not Subject to Multiple Procedure Reductions								

Exhibit 2

Dental Fee Schedule

CDT*[-3]*	**Description**	**NORTH**	**SOUTH**
…			
D0210	***intraoral - complete series (including bitewings)***	***153***	***135***
…			
D7880	occlusal orthotic device, by report	*[1263]* ***1453***	*[1118]* ***1376***
…			

Exhibit 7

Hospital Outpatient Surgical Facility (HOSF) Fees

CPT* HCPCS	DESCRIPTION		Hospital Outpatient Surgical Facility Fees North	Hospital Outpatient Surgical Facility Fees South	Not Subject to Multiple Procedure Reductions	Packaged Item; No Separate Payment	Ancillary Services; Separate Payment
***Current Procedural Terminology (CPT) is copyright 2010 American Medical Association (AMA). All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. CPT® is a trademark of the American Medical Association.**							
0232T	NJX PLATELET PLASMA		182.27	156.22			AS
G0289	ARTHRO, LOOSE BODY + CHONDRO				X	N1	
10060	DRAIN SKIN ABSCESS		404.79	346.94			
10061	DRAIN SKIN ABSCESS		404.79	346.94			
10120	REMOVE FOREIGN BODY		741.84	635.83			
10121	REMOVE FOREIGN BODY		4,909.21	4,207.68			
10140	DRAIN HEMATOMA/FLUID		3,533.67	3,028.71			
10160	PUNCTURE DRAIN LESION		404.79	346.94			
10180	COMPLEX DRAIN WOUND		5,485.22	4,701.38			
11000	DEBRIDE INFECTED SKIN		741.84	635.83			
11001	DEBRIDE INFECTED SKIN, ADDED		247.20	211.88			
11010	DEBRIDE SKIN, FX		1,381.84	1,184.38			
11011	DEBRIDE SKIN/MUSCLE, FX		1,381.84	1,184.38			
11012	DEBRIDE SKIN/MUSCLE/BONE, FX		1,381.84	1,184.38			
11042	DEBRIDE SKIN/TISSUE		741.84	635.83			
11043	DEBRIDE TISSUE/MUSCLE		741.84	635.83			
11044	DEBRIDE TISSUE/MUSCLE/BONE		2,306.26	1,976.70			
11045	DEBRIDE SUBQ TISSUE ADD-ON		741.84	635.83			
11046	DEBRIDE MUSCLE/FASCIA ADD-ON		741.84	635.83			
11047	DEBRIDE BONE ADD-ON		2,306.26	1,976.70			
11055	TRIM SKIN LESION		247.20	211.88			
11056	TRIM SKIN LESIONS, 2 TO 4		247.20	211.88			
11057	TRIM SKIN LESIONS, OVER 4		247.20	211.88			
11100	BIOPSY SKIN LESION		406.64	348.53			
11101	BIOPSY SKIN, ADDED		247.20	211.88			
11200	REMOVE SKIN TAGS		247.20	211.88			
11300	SHAVE SKIN LESION		247.20	211.88			
11301	SHAVE SKIN LESION		247.20	211.88			
11302	SHAVE SKIN LESION		247.20	211.88			
11305	SHAVE SKIN LESION		247.20	211.88			
11306	SHAVE SKIN LESION		247.20	211.88			
11310	SHAVE SKIN LESION		247.20	211.88			
11311	SHAVE SKIN LESION		247.20	211.88			
11400	EXCISE TRT-EXT BENIGN+MARG 0.5 < CM		1,381.84	1,184.38			
11401	EXCISE TRT-EXT BENIGN+MARG 0.6-1 CM		1,381.84	1,184.38			
11402	EXCISE TRT-EXT BENIGN+MARG 1.1-2 CM		1,381.84	1,184.38			
11403	EXCISE TRT-EXT BENIGN+MARG 2.1-3 CM		2,306.26	1,976.70			
11404	EXCISE TRT-EXT BENIGN+MARG 3.1-4 CM		4,909.21	4,042.57			

11406	EXCISE TRT-EXT BENIGN+MARG > 4.0 CM		4,909.21	4,042.57			
11420	EXCISE H-F-NECK-SP BENIGN+MARG 0.5 <		2,306.26	1,976.70			
11421	EXCISE H-F-NECK-SP BENIGN+MARG 0.6-1		2,306.26	1,976.70			
11422	EXCISE H-F-NECK-SP BENIGN+MARG 1.1-2		2,306.26	1,976.70			
11423	EXCISE H-F-NECK-SP BENIGN+MARG 2.1-3		4,909.21	4,207.68			
11424	EXCISE H-F-NECK-SP BENIGN+MARG 3.1-4		4,909.21	4,207.68			
11426	EXCISE H-F-NECK-SP BENIGN+MARG > 4 CM		6,489.68	5,562.30			
11440	EXCISE FACE-MM BENIGN+MARG 0.5 < CM		1,381.84	1,184.38			
11441	EXCISE FACE-MM BENIGN+MARG 0.6-1 CM		1,381.84	1,184.38			
11442	EXCISE FACE-MM BENIGN+MARG 1.1-2 CM		2,306.26	1,976.70			
11443	EXCISE FACE-MM BENIGN+MARG 2.1-3 CM		2,306.26	1,976.70			
11444	EXCISE FACE-MM BENIGN+MARG 3.1-4 CM		2,306.26	1,976.70			
11719	TRIM NAIL(S)		117.49	100.70			
11720	DEBRIDE NAIL, 1-5		247.20	211.88			
11721	DEBRIDE NAIL, 6 OR MORE		247.20	211.88			
11730	REMOVE NAIL PLATE		247.20	211.88			
11732	REMOVE NAIL PLATE, ADDED		247.20	211.88			
11740	DRAIN BLOOD UNDER NAIL		117.49	100.70			
11750	REMOVE NAIL BED		1,381.84	1,184.38			
11752	REMOVE NAIL BED/FINGER TIP		6,489.68	5,562.30			
11760	REPAIR NAIL BED		361.97	310.24			
11762	RECONSTRUCT NAIL BED		4,673.83	4,005.94			
11765	EXCISE NAIL FOLD, TOE		247.20	211.88			
11900	INJECTION INTO SKIN LESIONS		247.20	211.88			
11901	ADDED SKIN LESIONS INJECTION		247.20	211.88			
11950	THERAPY FOR CONTOUR DEFECTS		361.97	310.24			
11951	THERAPY FOR CONTOUR DEFECTS		361.97	310.24			
11960	INSERT TISSUE EXPANDER(S)		6,050.71	5,186.06			
11981	INSERT DRUG IMPLANT DEVICE		182.27	156.22			AS
11982	REMOVE DRUG IMPLANT DEVICE		182.27	156.22			AS
12001	REPAIR SUPERFICIAL WOUND(S)		361.97	310.24			
12002	REPAIR SUPERFICIAL WOUND(S)		361.97	310.24			
12004	REPAIR SUPERFICIAL WOUND(S)		361.97	310.24			
12005	REPAIR SUPERFICIAL WOUND(S)		361.97	310.24			
12006	REPAIR SUPERFICIAL WOUND(S)		361.97	310.24			
12011	REPAIR SUPERFICIAL WOUND(S)		361.97	310.24			
12013	REPAIR SUPERFICIAL WOUND(S)		361.97	310.24			
12014	REPAIR SUPERFICIAL WOUND(S)		361.97	310.24			
12015	REPAIR SUPERFICIAL WOUND(S)		361.97	310.24			
12016	REPAIR SUPERFICIAL WOUND(S)		361.97	310.24			
12017	REPAIR SUPERFICIAL WOUND(S)		361.97	310.24			
12018	REPAIR SUPERFICIAL WOUND(S)		361.97	310.24			
12020	CLOSE SPLIT WOUND		1,260.61	1,080.47			
12021	CLOSE SPLIT WOUND		858.58	735.89			
12031	INTERMED WOUND REPAIR S/TRT/EXT		361.97	310.24			
12032	INTERMED WOUND REPAIR S/TRT/EXT		858.58	735.89			
12034	INTERMED WOUND REPAIR S/TRT/EXT		361.97	310.24			
12035	INTERMED WOUND REPAIR S/TRT/EXT		361.97	310.24			

12036	INTERMED WOUND REPAIR S/TRT/EXT		858.58	735.89			
12037	INTERMED WOUND REPAIR S/TRT/EXT		858.58	735.89			
12041	INTERMED WOUND REPAIR N-HF/GENITAL		361.97	310.24			
12042	INTERMED WOUND REPAIR N-HG/GENITAL		361.97	310.24			
12044	INTERMED WOUND REPAIR N-HG/GENITAL		361.97	310.24			
12045	INTERMED WOUND REPAIR N-HG/GENITAL		858.58	735.89			
12046	INTERMED WOUND REPAIR N-HG/GENITAL		858.58	735.89			
12047	INTERMED WOUND REPAIR N-HG/GENITAL		858.58	735.89			
12051	INTERMED WOUND REPAIR FACE/MM		858.58	735.89			
12052	INTERMED WOUND REPAIR FACE/MM		361.97	310.24			
12053	INTERMED WOUND REPAIR FACE/MM		361.97	310.24			
12054	INTERMED WOUND REPAIR FACE/MM		361.97	310.24			
12055	INTERMED WOUND REPAIR FACE/MM		858.58	735.89			
12056	INTERMED WOUND REPAIR FACE/MM		858.58	735.89			
12057	INTERMED WOUND REPAIR FACE/MM		858.58	735.89			
13100	REPAIR WOUND OR LESION		1,260.61	1,080.47			
13101	REPAIR WOUND OR LESION		1,260.61	1,080.47			
13102	REPAIR WOUND/LESION, ADDED		1,260.61	1,080.47			
13120	REPAIR WOUND OR LESION		858.58	735.89			
13121	REPAIR WOUND OR LESION		858.58	735.89			
13122	REPAIR WOUND/LESION, ADDED		361.97	310.24			
13131	REPAIR WOUND OR LESION		858.58	735.89			
13132	REPAIR WOUND OR LESION		1,260.61	1,080.47			
13133	REPAIR WOUND/LESION, ADDED		858.58	735.89			
13150	REPAIR WOUND OR LESION		1,260.61	1,080.47			
13151	REPAIR WOUND OR LESION		1,260.61	1,080.47			
13152	REPAIR WOUND OR LESION		1,260.61	1,080.47			
13153	REPAIR WOUND/LESION, ADDED		858.58	735.89			
13160	LATE CLOSE WOUND		6,050.71	5,186.06			
14000	SKIN TISSUE REARRANGEMENT		4,673.83	4,005.94			
14001	SKIN TISSUE REARRANGEMENT		4,673.83	4,005.94			
14020	SKIN TISSUE REARRANGEMENT		4,673.83	4,005.94			
14021	SKIN TISSUE REARRANGEMENT		4,673.83	4,005.94			
14040	SKIN TISSUE REARRANGEMENT		4,673.83	4,005.94			
14041	SKIN TISSUE REARRANGEMENT		4,673.83	4,005.94			
14060	SKIN TISSUE REARRANGEMENT		4,673.83	4,005.94			
14061	SKIN TISSUE REARRANGEMENT		4,673.83	4,005.94			
14301	SKIN TISSUE REARRANGEMENT		6,050.71	5,186.06			
14302	SKIN TISSUE REARRANGE ADDED		6,050.71	5,186.06			
15002	WOUND PREP, TRUNK/ARM/LEG		1,260.61	1,080.47			
15003	WOUND PREP, ADDED 100 CM		1,260.61	1,080.47			
15004	WOUND PREP, F/N/HF/G		1,260.61	1,080.47			
15005	WOUND PREP, F/N/HF/G, ADDED CM		1,260.61	1,080.47			
15050	SKIN PINCH GRAFT		1,260.61	1,080.47			
15100	SKIN SPLIT GRAFT, TRUNK/ARM/LEG		6,050.71	5,186.06			
15101	SKIN SPLIT GRAFT T/A/L, ADDED		6,050.71	5,186.06			
15120	SKIN SPLIT A-GRAFT FAC/NECK/HF/G		6,050.71	5,186.06			
15121	SKIN SPLIT A-GRAFT F/N/HF/G ADDED		6,050.71	5,186.06			

15130	DERM AUTOGRAFT, TRUNK/ARM/LEG		4,673.83	4,005.94			
15170	ACELLULAR GRAFT TRUNK/ARMS/LEGS		1,260.61	1,080.47			
15171	ACELLULAR GRAFT T/ARM/LEG, ADDED		858.58	735.89			
15175	ACELLULAR GRAFT, F/N/HF/G		1,260.61	1,080.47			
15220	SKIN FULL GRAFT SCALP/ARM/LEG		4,673.83	4,005.94			
15221	SKIN FULL GRAFT, ADDED		1,260.61	1,080.47			
15240	SKIN FULL GRAFT FACE/GENITAL/HF		4,673.83	4,005.94			
15241	SKIN FULL GRAFT, ADDED		1,260.61	1,080.47			
15260	SKIN FULL GRAFT EEN & LIPS		4,673.83	4,005.94			
15330	APPLY ACELLULAR ALLOGRAFT T/ARM/LEG		1,260.61	1,080.47			
15331	APPLY ACELLULAR GRAFT T/A/L, ADDED		1,260.61	1,080.47			
15340	APPLY CULT SKIN SUBSTITUTE		858.58	735.89			
15341	APPLY CULT SKIN SUB, ADDED		858.58	735.89			
15365	APPLY CULT DERM SUB F/N/HF/G		858.58	735.89			
15366	APPLY CULT DERM F/HF/G ADDED		858.58	735.89			
15430	APPLY ACELLULAR XENOGRAFT		1,260.61	1,080.47			
15431	APPLY ACELLULAR XENOGRAFT ADDED		1,260.61	1,080.47			
15570	FORM SKIN PEDICLE FLAP		6,050.71	5,186.06			
15572	FORM SKIN PEDICLE FLAP		6,050.71	5,186.06			
15574	FORM SKIN PEDICLE FLAP		6,050.71	5,186.06			
15576	FORM SKIN PEDICLE FLAP		6,050.71	5,186.06			
15620	SKIN GRAFT		6,050.71	5,186.06			
15732	MUSCLE-SKIN GRAFT, HEAD/NECK		6,050.71	5,186.06			
15734	MUSCLE-SKIN GRAFT, TRUNK		6,050.71	5,186.06			
15736	MUSCLE-SKIN GRAFT, ARM		6,050.71	5,186.06			
15738	MUSCLE-SKIN GRAFT, LEG		6,050.71	5,186.06			
15770	DERMA-FAT-FASCIA GRAFT		6,050.71	5,186.06			
15780	ABRASION TREAT SKIN		6,489.68	5,562.30			
15781	ABRASION TREAT SKIN		1,381.84	1,184.38			
15782	ABRASION TREAT SKIN		1,381.84	1,184.38			
15786	ABRASION, LESION, SING		247.20	211.88			
15787	ABRASION, LESIONS, ADDED		247.20	211.88			
15823	REVISE UPPER EYELID		6,050.71	5,186.06			
15830	EXCISE SKIN ABD		6,489.68	5,562.30			
15832	EXCISE EXCESSIVE SKIN TISSUE		6,489.68	5,562.30			
15851	REMOVE SUTURES		741.84	635.83			
15852	DRESSING CHANGE NOT FOR BURN		182.27	156.22			AS
15940	REMOVE HIP PRESSURE SORE		6,489.68	5,562.30			
15941	REMOVE HIP PRESSURE SORE		6,489.68	5,562.30			
15944	REMOVE HIP PRESSURE SORE		6,050.71	5,186.06			
15945	REMOVE HIP PRESSURE SORE		6,050.71	5,186.06			
15946	REMOVE HIP PRESSURE SORE		6,050.71	5,186.06			
15950	REMOVE THIGH PRESSURE SORE		6,489.68	5,562.30			
15951	REMOVE THIGH PRESSURE SORE		6,489.68	5,562.30			
15952	REMOVE THIGH PRESSURE SORE		4,673.83	4,005.94			
15953	REMOVE THIGH PRESSURE SORE		4,673.83	4,005.94			
15956	REMOVE THIGH PRESSURE SORE		4,673.83	4,005.94			
15958	REMOVE THIGH PRESSURE SORE		4,673.83	4,005.94			

16000	INITIAL TREAT BURN(S)		247.20	211.88			
16020	DRESS/DEBRIDE P-THICK BURN, S		406.64	348.53			
16025	DRESS/DEBRIDE P-THICK BURN, M		406.64	348.53			
16030	DRESS/DEBRIDE P-THICK BURN, L		406.64	348.53			
17000	DESTROY PREMALIG LESION		247.20	211.88			
17003	DESTROY PREMALIG LES, 2-14		117.49	100.70			
17004	DESTROY PREMALIG LESIONS 15+		741.84	635.83			
17106	DESTROY SKIN LESIONS		741.84	635.83			
17107	DESTROY SKIN LESIONS		741.84	635.83			
17108	DESTROY SKIN LESIONS		741.84	635.83			
17110	DESTROY B9 LESION, 1-14		247.20	211.88			
17111	DSTRJ B9 SK TGS/CUTAN VASC 15/>		406.64	348.53			
17250	CHEM CAUT GRANLTJ TISS PROUD FLESH SINUS/FSTL		406.64	348.53			
17261	DESTROY SKIN LESIONS		406.64	348.53			
17262	DESTROY SKIN LESIONS		406.64	348.53			
19000	DRAIN BREAST LESION		1,244.88	1,066.98			
19120	REMOVE BREAST LESION		6,949.27	5,956.21			
19125	EXCISE BREAST LESION		6,949.27	5,956.21			
19290	PLACE NEEDLE WIRE, BREAST					N1	
20100	EXPLORE WOUND, NECK		2,150.53	1,843.22			
20101	EXPLORE WOUND, CHEST		6,050.71	5,186.06			
20102	EXPLORE WOUND, ABDOMEN		6,050.71	5,186.06			
20103	EXPLORE WOUND, EXTREMITY		3,533.67	3,028.71			
20520	REMOVE FOREIGN BODY		6,238.69	5,347.18			
20525	REMOVE FOREIGN BODY		6,489.68	5,562.30			
20526	THERAPEUTIC INJECTION, CARP TUNNEL		724.57	621.03			
20550	INJECT TENDON SHEATH/LIGAMENT		724.57	621.03			
20551	INJECT TENDON ORIGIN/INSERT		724.57	621.03			
20552	INJECT TRIGGER POINT, 1/2 MUSCLE		724.57	621.03			
20553	INJECT TRIGGER POINTS, =/> 3		724.57	621.03			
20600	DRAIN/INJ, JOINT/BURSA		724.57	621.03			
20605	DRAIN/INJ, JOINT/BURSA		724.57	621.03			
20610	DRAIN/INJ, JOINT/BURSA		724.57	621.03			
20612	ASPIRATE/INJECT GANGLION CYST		724.57	621.03			
20615	TREAT BONE CYST		1,244.88	1,066.98			
20650	INSERT & REMOVE BONE PIN		6,238.69	5,347.18			
20660	APPLY, REM FIXATION DEVICE		1,494.88	1,281.26			
20662	APPLY PELVIS BRACE		6,238.69	5,347.18			
20663	APPLY THIGH BRACE		6,238.69	5,347.18			
20665	REMOVE FIXATION DEVICE		182.27	156.22			AS
20670	REMOVE SUPPORT IMPLANT		4,909.21	4,207.68			
20680	REMOVE SUPPORT IMPLANT		6,489.68	5,562.30			
20690	APPLY BONE FIXATION DEVICE		8,755.84	7,504.63			
20692	APPLY BONE FIXATION DEVICE		8,755.84	7,504.63			
20693	ADJUST BONE FIXATION DEVICE		6,238.69	5,347.18			
20694	REMOVE BONE FIXATION DEVICE		6,238.69	5,347.18			
20696	COMP MULTIPLANE EXT FIXATION		8,755.84	7,504.63			
20697	COMP EXT FIXATE STRUT CHANGE		5,657.91	4,849.39			

20900	REMOVE BONE FOR GRAFT		8,755.84	7,504.63			
20902	REMOVE BONE FOR GRAFT		8,755.84	7,504.63			
20910	REMOVE CARTILAGE FOR GRAFT		6,050.71	5,186.06			
20912	REMOVE CARTILAGE FOR GRAFT		6,050.71	5,186.06			
20920	REMOVE FASCIA FOR GRAFT		4,673.83	4,005.94			
20922	REMOVE FASCIA FOR GRAFT		4,673.83	4,005.94			
20924	REMOVE TENDON FOR GRAFT		8,755.84	7,504.63			
20926	REMOVE TISSUE FOR GRAFT		1,260.61	1,080.47			
20950	FLUID PRESSURE, MUSCLE		404.79	346.94			
20975	ELECTRICAL BONE STIMULATION					N1	
20979	US BONE STIMULATION		182.27	156.22			AS
20985	COMPUTER-ASSIST DIR MS PX					N1	
21060	REMOVE JAW JOINT CARTILAGE		12,135.56	10,401.38			
21070	REMOVE CORONOID PROCESS		12,135.56	10,401.38			
21073	MANIPULATE TMJ W/ANESTH		2,150.53	1,843.22			
21085	PREPARE FACE/ORAL PROSTHESIS		4,708.37	4,035.54			
21110	INTERDENTAL FIXATION		2,150.53	1,843.22			
21116	INJECTION, JAW JOINT X-RAY					N1	
21209	REDUCE FACIAL BONES		12,135.56	10,401.38			
21210	FACE BONE GRAFT		12,135.56	10,401.38			
21240	RECONSTRUCT JAW JOINT		12,135.56	10,401.38			
21242	RECONSTRUCT JAW JOINT		12,135.56	10,401.38			
21243	RECONSTRUCT JAW JOINT		12,135.56	10,401.38			
21244	RECONSTRUCT LOWER JAW		12,135.56	10,401.38			
21245	RECONSTRUCT JAW		12,135.56	10,401.38			
21246	RECONSTRUCT JAW		12,135.56	10,401.38			
21248	RECONSTRUCT JAW		12,135.56	10,401.38			
21249	RECONSTRUCT JAW		12,135.56	10,401.38			
21310	TREAT NOSE FX		307.68	263.71			
21315	TREAT NOSE FX		4,708.37	4,035.54			
21320	TREAT NOSE FX		4,708.37	4,035.54			
21325	TREAT NOSE FX		6,964.52	5,969.29			
21330	TREAT NOSE FX		6,964.52	5,969.29			
21335	TREAT NOSE FX		6,964.52	5,969.29			
21356	TREAT CHEEK BONE FX		6,964.52	5,969.29			
21360	TREAT CHEEK BONE FX		6,964.52	5,969.29			
21365	TREAT CHEEK BONE FX		12,135.56	10,401.38			
21385	TREAT EYE SOCKET FX		12,135.56	10,401.38			
21386	TREAT EYE SOCKET FX		12,135.56	10,401.38			
21390	TREAT EYE SOCKET FX		12,135.56	10,401.38			
21395	TREAT EYE SOCKET FX		12,135.56	10,401.38			
21400	TREAT EYE SOCKET FX		2,150.53	1,843.22			
21401	TREAT EYE SOCKET FX		4,708.37	4,035.54			
21406	TREAT EYE SOCKET FX		12,135.56	10,401.38			
21407	TREAT EYE SOCKET FX		12,135.56	10,401.38			
21408	TREAT EYE SOCKET FX		12,135.56	10,401.38			
21450	TREAT LOWER JAW FX		965.03	827.13			
21451	TREAT LOWER JAW FX		2,150.53	1,843.22			

21452	TREAT LOWER JAW FX		4,708.37	4,035.54			
21453	TREAT LOWER JAW FX		12,135.56	10,401.38			
21454	TREAT LOWER JAW FX		6,964.52	5,969.29			
21461	TREAT LOWER JAW FX		12,135.56	10,401.38			
21462	TREAT LOWER JAW FX		12,135.56	10,401.38			
21465	TREAT LOWER JAW FX		12,135.56	10,401.38			
21470	TREAT LOWER JAW FX		12,135.56	10,401.38			
21800	TREAT RIB FX		428.68	367.42			
21820	TREAT STERNUM FX		428.68	367.42			
22222	REVISE THORAX SPINE		13,940.72	11,948.58			
22305	TREAT SPINE PROCESS FX		428.68	367.42			
22310	TREAT SPINE FX		1,494.88	1,281.26			
22315	TREAT SPINE FX		5,657.91	4,849.39			
22505	MANIPULATE SPINE		4,222.92	3,619.46			
22520	PERCUT VERTEBROPLASTY THORACIC		8,755.84	7,504.63			
22521	PERCUT VERTEBROPLASTY LUMBAR		8,755.84	7,504.63			
22522	PERCUT VERTEBROPLASTY ADDED		8,755.84	7,504.63			
22612	LUMBAR SPINE FUSION		13,940.72	11,948.58			
22614	SPINE FUSION, EXTRA SEGMENT		13,940.72	11,948.58			
22851	APPLY SPINE PROSTH DEVICE		6,238.69	5,347.18			
23120	PARTIAL REMOVE COLLAR BONE		8,755.84	7,504.63			
23125	REMOVE COLLAR BONE		8,755.84	7,504.63			
23130	REMOVE SHOULDER BONE, PART		12,850.12	11,013.83			
23331	REMOVE SHOULDER FOREIGN BODY		6,489.68	5,562.30			
23350	INJECTION FOR SHOULDER X-RAY					N1	
23405	TX SHO AREA 1 TDN		8,755.84	7,504.63			
23406	TX SHO AREA MLT TDN THRU SM INC		8,755.84	7,504.63			
23410	OPEN REPAIR OF ROTATOR CUFF, RECENT		12,850.12	11,013.83			
23412	OPEN REPAIR OF ROTATOR CUFF, OLD		12,850.12	11,013.83			
23415	CORACOACROMIAL LIGM RLS +-ACROMP		12,850.12	11,013.83			
23420	RECONSTRUCTION ROTATOR CUFF, OLD		12,850.12	11,013.83			
23430	TENODIS LONG TDN BICEPS		12,850.12	11,013.83			
23440	RESCJ/TRNSPLJ LONG TDN BICEPS		12,850.12	11,013.83			
23470	RECONSTRUCT SHOULDER JOINT		19,460.64	17,581.99			
23480	REVISE COLLAR BONE		12,850.12	11,013.83			
23485	REVISE COLLAR BONE		24,164.43	20,711.32			
23500	TREAT CLAVICLE FX		428.68	367.42			
23505	TREAT CLAVICLE FX		5,657.91	4,849.39			
23515	TREAT CLAVICLE FX		18,168.29	15,572.03			
23520	TREAT CLAVICLE DISLOCATION		1,494.88	1,281.26			
23525	TREAT CLAVICLE DISLOCATION		1,494.88	1,281.26			
23530	TREAT CLAVICLE DISLOCATION		13,070.23	11,202.49			
23540	TREAT CLAVICLE DISLOCATION		428.68	367.42			
23545	TREAT CLAVICLE DISLOCATION		1,494.88	1,281.26			
23550	TREAT CLAVICLE DISLOCATION		13,070.23	11,202.49			
23552	TREAT CLAVICLE DISLOCATION		13,070.23	11,202.49			
23570	TREAT SHOULDER BLADE FX		428.68	367.42			
23600	TREAT HUMERUS FX		428.68	367.42			

23605	TREAT HUMERUS FX		5,657.91	4,849.39			
23615	TREAT HUMERUS FX		18,168.29	15,572.03			
23616	TREAT HUMERUS FX		18,168.29	15,572.03			
23620	TREAT HUMERUS FX		428.68	367.42			
23625	TREAT HUMERUS FX		5,657.91	4,849.39			
23630	TREAT HUMERUS FX		18,168.29	15,572.03			
23650	TREAT SHOULDER DISLOCATION		428.68	367.42			
23655	TREAT SHOULDER DISLOCATION		4,222.92	3,619.46			
23700	FIXATE SHOULDER		4,222.92	3,619.46			
24220	INJECTION FOR ELBOW X-RAY					N1	
24300	MANIPULATE ELBOW W/ANESTH		4,222.92	3,619.46			
24305	ARM TENDON LENGTHENING		8,755.84	7,504.63			
24340	REPAIR BICEPS TENDON		12,850.12	11,013.83			
24341	REPAIR ARM TENDON/MUSCLE		12,850.12	11,013.83			
24342	REPAIR RUPTURED TENDON		12,850.12	11,013.83			
24343	REPAIR ELBOW LAT LIGAMENT W/TISS		8,755.84	7,504.63			
24500	TREAT HUMERUS FX		428.68	367.42			
24505	TREAT HUMERUS FX		428.68	367.42			
24515	TREAT HUMERUS FX		18,168.29	15,572.03			
24516	TREAT HUMERUS FX		18,168.29	15,572.03			
24530	TREAT HUMERUS FX		428.68	367.42			
24535	TREAT HUMERUS FX		1,494.88	1,281.26			
24545	TREAT HUMERUS FX		18,168.29	15,572.03			
24546	TREAT HUMERUS FX		18,168.29	15,572.03			
24560	TREAT HUMERUS FX		428.68	367.42			
24565	TREAT HUMERUS FX		428.68	367.42			
24575	TREAT HUMERUS FX		18,168.29	15,572.03			
24576	TREAT HUMERUS FX		428.68	367.42			
24577	TREAT HUMERUS FX		428.68	367.42			
24579	TREAT HUMERUS FX		18,168.29	15,572.03			
25000	INCISE TENDON SHEATH		6,238.69	5,347.18			
25001	INCISE FLEXOR CARPI RADIALIS		6,238.69	5,347.18			
25020	DECOMPRESS FOREARM 1 SPACE		8,755.84	7,504.63			
25023	DECOMPRESS FOREARM 1 SPACE		8,755.84	7,504.63			
25024	DECOMPRESS FOREARM 2 SPACES		8,755.84	7,504.63			
25025	DECOMPRESS FOREARM 2 SPACES		8,755.84	7,504.63			
25118	EXCISE WRIST TENDON SHEATH		8,755.84	7,504.63			
25215	REMOVE WRIST BONES		8,755.84	7,504.63			
25246	INJECTION FOR WRIST X-RAY					N1	
25259	MANIPULATE WRIST W/ANESTH		5,657.91	4,849.39			
25260	REPAIR FOREARM TENDON/MUSCLE		8,755.84	7,504.63			
25263	REPAIR FOREARM TENDON/MUSCLE		8,755.84	7,504.63			
25265	REPAIR FOREARM TENDON/MUSCLE		8,755.84	7,504.63			
25270	REPAIR FOREARM TENDON/MUSCLE		8,755.84	7,504.63			
25272	REPAIR FOREARM TENDON/MUSCLE		8,755.84	7,504.63			
25274	REPAIR FOREARM TENDON/MUSCLE		8,755.84	7,504.63			
25295	RELEASE WRIST/FOREARM TENDON		6,238.69	5,347.18			
25500	TREAT FX RADIUS		428.68	367.42			

25505	TREAT FX RADIUS		1,494.88	1,281.26			
25515	TREAT FX RADIUS		13,070.23	11,202.49			
25525	TREAT FX RADIUS		13,070.23	11,202.49			
25526	TREAT FX RADIUS		13,070.23	11,202.49			
25530	TREAT FX ULNA		428.68	367.42			
25535	TREAT FX ULNA		428.68	367.42			
25545	TREAT FX ULNA		13,070.23	11,202.49			
25560	TREAT FX RADIUS & ULNA		428.68	367.42			
25565	TREAT FX RADIUS & ULNA		1,494.88	1,281.26			
25574	TREAT FX RADIUS & ULNA		18,168.29	15,572.03			
25575	TREAT FX RADIUS/ULNA		18,168.29	15,572.03			
25600	TREAT FX RADIUS/ULNA		428.68	367.42			
25605	TREAT FX RADIUS/ULNA		1,494.88	1,281.26			
25606	TREAT FX DISTAL RADIAL		7,210.82	6,180.39			
25607	TREAT FX RADIAL EXTRA-ARTICULAR		18,168.29	15,572.03			
25608	TREAT FX RADIAL INTRA-ARTICULAR		18,168.29	15,572.03			
25609	TREAT FX RADIAL 3+ FRAG		18,168.29	15,572.03			
25622	TREAT WRIST BONE FX		428.68	367.42			
25624	TREAT WRIST BONE FX		1,494.88	1,281.26			
25628	TREAT WRIST BONE FX		13,070.23	11,202.49			
25630	TREAT WRIST BONE FX		428.68	367.42			
25635	TREAT WRIST BONE FX		428.68	367.42			
25645	TREAT WRIST BONE FX		13,070.23	11,202.49			
25650	TREAT WRIST BONE FX		428.68	367.42			
25652	TREAT FX ULNAR STYLOID		13,070.23	11,202.49			
25670	TREAT FX ULNAR STYLOID		7,210.82	6,180.39			
25671	TREAT FX ULNAR STYLOID		7,210.82	6,180.39			
25676	TREAT WRIST DISLOCATION		7,210.82	6,180.39			
25680	TREAT WRIST FX		428.68	367.42			
25685	TREAT WRIST FX		7,210.82	6,180.39			
26055	INCISE FINGER TENDON SHEATH		4,660.94	3,994.89			
26116	EXCISE HAND TUMOR DEEP < 1.5 CM		4,909.21	4,207.68			
26140	REVISE FINGER JOINT, EACH		4,660.94	3,994.89			
26145	TENDON EXCISE PALM/FINGER		4,660.94	3,994.89			
26340	MANIPULATE FINGER W/ANESTH		1,494.88	1,281.26			
26410	REPAIR HAND TENDON		4,660.94	3,994.89			
26418	REPAIR FINGER TENDON		4,660.94	3,994.89			
26445	RELEASE HAND/FINGER TENDON		4,660.94	3,994.89			
26480	TRANSPLANT HAND TENDON		8,083.67	6,928.51			
26525	RELEASE FINGER CONTRACTURE		4,660.94	3,994.89			
26540	REPAIR HAND JOINT		4,660.94	3,994.89			
26600	TREAT METACARPAL FX		428.68	367.42			
26605	TREAT METACARPAL FX		428.68	367.42			
26607	TREAT METACARPAL FX		5,657.91	4,849.39			
26608	TREAT METACARPAL FX		7,210.82	6,180.39			
26615	TREAT METACARPAL FX		13,070.23	11,202.49			
26720	TREAT FINGER FX, EACH		428.68	367.42			
26725	TREAT FINGER FX, EACH		428.68	367.42			

26727	TREAT FINGER FX, EACH		7,210.82	6,180.39			
26735	TREAT FINGER FX, EACH		7,210.82	6,180.39			
26740	TREAT FINGER FX, EACH		428.68	367.42			
26742	TREAT FINGER FX, EACH		428.68	367.42			
26746	TREAT FINGER FX, EACH		7,210.82	6,180.39			
26750	TREAT FINGER FX, EACH		428.68	367.42			
26755	TREAT FINGER FX, EACH		428.68	367.42			
27093	INJECTION FOR HIP X-RAY					N1	
27095	INJECTION FOR HIP X-RAY					N1	
27193	TREAT PELVIC RING FX		428.68	367.42			
27194	TREAT PELVIC RING FX		4,222.92	3,619.46			
27275	MANIPULATE HIP JOINT		4,222.92	3,619.46			
27403	REPAIR KNEE CARTILAGE		8,755.84	7,504.63			
27405	REPAIR KNEE LIGAMENT		12,850.12	11,013.83			
27420	REVISE UNSTABLE KNEECAP		12,850.12	11,013.83			
27422	REVISE UNSTABLE KNEECAP		12,850.12	11,013.83			
27424	REVISION/REMOVE KNEECAP		12,850.12	11,013.83			
27500	TREAT THIGH FX		1,494.88	1,281.26			
27501	TREAT THIGH FX		428.68	367.42			
27502	TREAT THIGH FX		5,657.91	4,849.39			
27503	TREAT THIGH FX		428.68	367.42			
27508	TREAT THIGH FX		428.68	367.42			
27509	TREAT THIGH FX		7,210.82	6,180.39			
27510	TREAT THIGH FX		1,494.88	1,281.26			
27520	TREAT KNEECAP FX		428.68	367.42			
27524	TREAT KNEECAP FX		13,070.23	11,202.49			
27530	TREAT KNEE FX		428.68	367.42			
27532	TREAT KNEE FX		5,657.91	4,849.39			
27538	TREAT KNEE FX(S)		428.68	367.42			
27570	FIXATE KNEE JOINT		4,222.92	3,619.46			
27685	REVISE LOWER LEG TENDON		8,755.84	7,504.63			
27686	REVISE LOWER LEG TENDONS		8,755.84	7,504.63			
27690	REVISE LOWER LEG TENDON		12,850.12	11,013.83			
27691	REVISE LOWER LEG TENDON		12,850.12	11,013.83			
27692	REVISE ADDEDITIONAL LEG TENDON		12,850.12	11,013.83			
27695	REPAIR ANKLE LIGAMENT		8,755.84	7,504.63			
27696	REPAIR ANKLE LIGAMENTS		8,755.84	7,504.63			
27698	REPAIR ANKLE LIGAMENT		8,755.84	7,504.63			
27750	TREAT TIBIA FX		428.68	367.42			
27752	TREAT TIBIA FX		5,657.91	4,849.39			
27758	TREAT TIBIA FX		13,070.23	11,202.49			
27759	TREAT TIBIA FX		18,168.29	15,572.03			
27760	CLOSED TREAT MEDIAL ANKLE FX		428.68	367.42			
27762	CLOSED TREAT MED ANKLE FX W/MANIP		5,657.91	4,849.39			
27766	OPEN TREAT MEDIAL ANKLE FX		13,070.23	11,202.49			
27786	TREAT ANKLE FX		428.68	367.42			
27788	TREAT ANKLE FX		428.68	367.42			
27792	TREAT ANKLE FX		13,070.23	11,202.49			

27808	TREAT ANKLE FX		428.68	367.42			
27810	TREAT ANKLE FX		428.68	367.42			
27814	TREAT ANKLE FX		13,070.23	11,202.49			
27816	TREAT ANKLE FX		428.68	367.42			
27818	TREAT ANKLE FX		1,494.88	1,281.26			
27822	TREAT ANKLE FX		13,070.23	11,202.49			
27823	TREAT ANKLE FX		18,168.29	15,572.03			
27824	TREAT LOWER LEG FX		428.68	367.42			
27825	TREAT LOWER LEG FX		5,657.91	4,849.39			
27826	TREAT LOWER LEG FX		13,070.23	11,202.49			
27827	TREAT LOWER LEG FX		18,168.29	15,572.03			
27828	TREAT LOWER LEG FX		18,168.29	15,572.03			
27829	TREAT LOWER LEG JOINT		13,070.23	11,202.49			
27840	TREAT ANKLE DISLOCATION		428.68	367.42			
27842	TREAT ANKLE DISLOCATION		4,222.92	3,619.46			
27846	TREAT ANKLE DISLOCATION		13,070.23	11,202.49			
27848	TREAT ANKLE DISLOCATION		13,070.23	11,202.49			
27860	FIXATE ANKLE JOINT		4,222.92	3,619.46			
28120	PART REMOVE ANKLE/HEEL		6,135.71	5,258.91			
28122	PARTIAL REMOVE FOOT BONE		6,135.71	5,258.91			
28400	TREAT HEEL FX		428.68	367.42			
28405	TREAT HEEL FX		5,657.91	4,849.39			
28415	TREAT HEEL FX		18,168.29	15,572.03			
28420	TREAT/GRAFT HEEL FX		13,070.23	11,202.49			
28430	TREAT ANKLE FX		428.68	367.42			
28435	TREAT ANKLE FX		428.68	367.42			
28436	TREAT ANKLE FX		7,210.82	6,180.39			
28445	TREAT ANKLE FX		13,070.23	11,202.49			
28470	TREAT METATARSAL FX		428.68	367.42			
28475	TREAT METATARSAL FX		428.68	367.42			
28476	TREAT METATARSAL FX		7,210.82	6,180.39			
28485	TREAT METATARSAL FX		13,070.23	11,202.49			
28725	FUSE FOOT BONES		15,005.30	12,861.03			
28730	FUSE FOOT BONES		15,005.30	12,861.03			
28740	FUSE FOOT BONES		15,005.30	12,861.03			
28750	FUSE BIG TOE JOINT		15,005.30	12,861.03			
29065	APPLY LONG ARM CAST		691.49	592.68	X		
29075	APPLY FOREARM CAST		691.49	592.68	X		
29085	APPLY HAND/WRIST CAST		304.17	260.71	X		
29086	APPLY FINGER CAST		304.17	260.71	X		
29105	APPLY LONG ARM SPLINT		304.17	260.71	X		
29125	APPLY FOREARM SPLINT		304.17	260.71	X		
29126	APPLY FOREARM SPLINT		304.17	260.71	X		
29130	APPLY FINGER SPLINT		304.17	260.71	X		
29131	APPLY FINGER SPLINT		304.17	260.71	X		
29200	STRAP CHEST		304.17	260.71	X		
29240	STRAP SHOULDER		304.17	260.71	X		
29260	STRAP ELBOW OR WRIST		304.17	260.71	X		

29280	STRAP HAND OR FINGER		304.17	260.71	X		
29345	APPLY LONG LEG CAST		691.49	592.68	X		
29355	APPLY LONG LEG CAST		691.49	592.68	X		
29365	APPLY LONG LEG CAST		691.49	592.68	X		
29405	APPLY SHORT LEG CAST		691.49	592.68	X		
29425	APPLY SHORT LEG CAST		691.49	592.68	X		
29450	APPLY LEG CAST		304.17	260.71	X		
29505	APPLY LONG LEG SPLINT		304.17	260.71	X		
29515	APPLY LOWER LEG SPLINT		304.17	260.71	X		
29520	STRAP HIP		304.17	260.71	X		
29530	STRAP KNEE		304.17	260.71	X		
29540	STRAP ANKLE AND/OR FT		304.17	260.71	X		
29550	STRAP TOES		304.17	260.71	X		
29580	APPLY PASTE BOOT		304.17	260.71	X		
29581	APPLY MULTILAY COMPRESS LWR LEG		304.17	260.71	X		
29590	APPLY FOOT SPLINT		304.17	260.71	X		
29700	REMOVE/REVISE CAST		304.17	260.71	X		
29705	REMOVE/REVISE CAST		304.17	260.71	X		
29710	REMOVE/REVISE CAST		691.49	592.68	X		
29740	WEDGE CAST		304.17	260.71	X		
29800	JAW ARTHROSCOPY/SURG		8,137.61	6,974.74			
29804	JAW ARTHROSCOPY/SURG		8,137.61	6,974.74			
29805	SHOULDER ARTHROSCOPY, DIAG		8,137.61	6,974.74			
29806	SHOULDER ARTHROSCOPY/SURG		13,154.68	11,274.87			
29807	SHOULDER ARTHROSCOPY/SURG		13,154.68	11,274.87			
29819	SHOULDER ARTHROSCOPY/SURG		13,154.68	11,274.87			
29820	SHOULDER ARTHROSCOPY/SURG		13,154.68	11,274.87			
29821	SHOULDER ARTHROSCOPY/SURG		13,154.68	11,274.87			
29822	SHOULDER ARTHROSCOPY/SURG		8,137.61	6,974.74			
29823	SHOULDER ARTHROSCOPY/SURG		13,154.68	11,274.87			
29824	SHOULDER ARTHROSCOPY/SURG		8,137.61	6,974.74			
29825	SHOULDER ARTHROSCOPY/SURG		13,154.68	11,274.87			
29826	SHOULDER ARTHROSCOPY/SURG		13,154.68	11,274.87			
29827	ARTHROSCOPY ROTATOR CUFF REPAIR		13,154.68	11,274.87			
29828	ARTHROSCOPY BICEPS TENODESIS		13,154.68	11,274.87			
29830	ELBOW ARTHROSCOPY		8,137.61	6,974.74			
29834	ELBOW ARTHROSCOPY/SURG		8,137.61	6,974.74			
29835	ELBOW ARTHROSCOPY/SURG		8,137.61	6,974.74			
29837	ELBOW ARTHROSCOPY/SURG		8,137.61	6,974.74			
29840	WRIST ARTHROSCOPY		8,137.61	6,974.74			
29844	WRIST ARTHROSCOPY/SURG		8,137.61	6,974.74			
29845	WRIST ARTHROSCOPY/SURG		8,137.61	6,974.74			
29846	WRIST ARTHROSCOPY/SURG		8,137.61	6,974.74			
29847	WRIST ARTHROSCOPY/SURG		13,154.68	11,274.87			
29848	WRIST ENDOSCOPY/SURG		8,137.61	6,974.74			
29850	KNEE ARTHROSCOPY/SURG		8,137.61	6,974.74			
29855	TIBIAL ARTHROSCOPY/SURG		13,154.68	11,274.87			
29860	HIP ARTHROSCOPY, DIAG		13,154.68	11,274.87			

29861	HIP ARTHROSCOPY/SURG		13,154.68	11,274.87			
29862	HIP ARTHROSCOPY/SURG		13,154.68	11,274.87			
29863	HIP ARTHROSCOPY/SURG		13,154.68	11,274.87			
29870	KNEE ARTHROSCOPY, DIAG		8,137.61	6,974.74			
29871	KNEE ARTHROSCOPY/DRAIN		8,137.61	6,974.74			
29873	KNEE ARTHROSCOPY/SURG		8,137.61	6,974.74			
29874	KNEE ARTHROSCOPY/SURG		8,137.61	6,974.74			
29875	KNEE ARTHROSCOPY/SURG		8,137.61	6,974.74			
29876	KNEE ARTHROSCOPY/SURG		8,137.61	6,974.74			
29877	KNEE ARTHROSCOPY/SURG		8,137.61	6,974.74			
29879	KNEE ARTHROSCOPY/SURG		8,137.61	6,974.74			
29880	KNEE ARTHROSCOPY/SURG		8,137.61	6,974.74			
29881	KNEE ARTHROSCOPY/SURG		8,137.61	6,974.74			
29882	KNEE ARTHROSCOPY/SURG		8,137.61	6,974.74			
29883	KNEE ARTHROSCOPY/SURG		8,137.61	6,974.74			
29884	KNEE ARTHROSCOPY/SURG		8,137.61	6,974.74			
29886	KNEE ARTHROSCOPY/SURG		8,137.61	6,974.74			
29887	KNEE ARTHROSCOPY/SURG		8,137.61	6,974.74			
29888	KNEE ARTHROSCOPY/SURG		24,164.43	20,711.32			
29889	KNEE ARTHROSCOPY/SURG		24,164.43	20,711.32			
29891	ANKLE ARTHROSCOPY/SURG		13,154.68	11,274.87			
29894	ANKLE ARTHROSCOPY/SURG		8,137.61	6,974.74			
29895	ANKLE ARTHROSCOPY/SURG		8,137.61	6,974.74			
29897	ANKLE ARTHROSCOPY/SURG		8,137.61	6,974.74			
29898	ANKLE ARTHROSCOPY/SURG		8,137.61	6,974.74			
29899	ANKLE ARTHROSCOPY/SURG		13,154.68	11,274.87			
30100	INTRANASAL BIOPSY		2,150.53	1,843.22			
30130	EXCISE INFERIOR TURBINATE		4,708.37	4,035.54			
30140	RESECT INFERIOR TURBINATE		6,964.52	5,969.29			
30200	INJECTION TREAT NOSE		2,150.53	1,843.22			
30300	REMOVE NASAL FOREIGN BODY		182.27	156.22			AS
30310	REMOVE NASAL FOREIGN BODY		4,708.37	4,035.54			
30520	REPAIR NASAL SEPTUM		6,964.52	5,969.29			
30802	ABLATE INF TURBINATE SUBMUCOSAL		4,708.37	4,035.54			
30901	CONTROL NOSEBLEED		307.68	263.71			
30903	CONTROL NOSEBLEED		307.68	263.71			
30905	CONTROL NOSEBLEED		307.68	263.71			
30930	THERAPEUTIC FX, NASAL INF TURB		4,708.37	4,035.54			
31000	IRRIGATE MAXILLARY SINUS		965.03	827.13			
31020	EXPLORE MAXILLARY SINUS		6,964.52	5,969.29			
31231	NASAL ENDOSCOPY, DIAG		546.21	468.15			
31237	NASAL/SINUS ENDOSCOPY, SURG		5,959.12	5,107.56			
31238	NASAL/SINUS ENDOSCOPY, SURG		5,959.12	5,107.56			
31255	REMOVE ETHMOID SINUS		8,403.49	7,202.63			
31256	EXPLORE MAXILLARY SINUS		8,403.49	7,202.63			
31267	ENDOSCOPY, MAXILLARY SINUS		8,403.49	7,202.63			
31500	INSERT EMERGENCY AIRWAY		642.80	550.94	X		
31505	DIAGNOSTIC LARYNGOSCOPY		252.44	216.37			

31515	LARYNGOSCOPY FOR ASPIRATION		5,959.12	5,107.56			
31525	DIAG LARYNGOSCOPY EXCL NB		5,959.12	5,107.56			
31575	DIAGNOSTIC LARYNGOSCOPY		546.21	468.15			
31579	DIAGNOSTIC LARYNGOSCOPY		1,147.30	983.35			
31600	INCISE WINDPIPE		6,964.52	5,969.29			
31605	INCISE WINDPIPE		2,150.53	1,843.22			
31622	DIAG BRONCHOSCOPE/WASH		2,851.45	2,443.97			
31624	DIAG BRONCHOSCOPE/LAVAGE		2,851.45	2,443.97			
31645	BRONCHOSCOPY, CLEAR AIRWAYS		2,851.45	2,443.97			
31646	BRONCHOSCOPY, RECLEAR AIRWAY		2,851.45	2,443.97			
32405	BIOPSY LUNG OR MEDIASTINUM		2,643.63	2,265.85			
32551	INSERT CHEST TUBE		1,510.65	1,294.77			
32601	THORACOSCOPY, DIAGNOSTIC		9,461.41	8,109.37			
33210	INSERT HEART ELECTRODE		9,299.39	8,275.58			
33212	INSERT PULSE GENERATOR		12,451.20	11,516.42			
36000	PLACE NEEDLE IN VEIN					N1	
36005	INJECTION EXT VENOGRAPHY					N1	
36010	PLACE CATHETER IN VEIN					N1	
36011	PLACE CATHETER IN VEIN					N1	
36013	PLACE CATHETER IN ARTERY					N1	
36014	PLACE CATHETER IN ARTERY					N1	
36140	ESTABLISH ACCESS TO ARTERY					N1	
36200	PLACE CATHETER IN AORTA					N1	
36215	PLACE CATHETER IN ARTERY					N1	
36216	PLACE CATHETER IN ARTERY					N1	
36217	PLACE CATHETER IN ARTERY					N1	
36218	PLACE CATHETER IN ARTERY					N1	
36245	PLACE CATHETER IN ARTERY					N1	
36246	PLACE CATHETER IN ARTERY					N1	
36247	PLACE CATHETER IN ARTERY					N1	
36248	PLACE CATHETER IN ARTERY					N1	
36400	BLOOD DRAW < 3 YRS FEM/JUGULAR					N1	
36406	BLOOD DRAW < 3 YRS OTHER VEIN					N1	
36410	NON-ROUTINE BL DRAW > 3 YRS					N1	
36425	VEIN ACCESS CUTDOWN > 1 YR		72.62	62.24			AS
36430	BLOOD TRANSFUSION SERVICE		921.03	789.41	X		
36471	INJECTION THERAPY VEINS		247.20	211.88			
36513	APHERESIS PLATELETS		3,363.75	2,883.07	X		
36514	APHERESIS PLASMA		3,363.75	2,883.07	X		
36515	APHERESIS, ADSORP/REINFUSE		8,540.97	7,320.46	X		
36555	INSERT NON-TUNNEL CV CATH		3,087.37	2,646.18			
36556	INSERT NON-TUNNEL CV CATH		3,087.37	2,646.18			
36558	INSERT TUNNELED CV CATH		5,241.41	4,907.68			
36569	INSERT PICC CATH		3,087.37	2,646.18			
36571	INSERT PICVAD CATH		5,241.41	4,907.68			
36576	REPAIR TUNNELED CV CATH		3,087.37	2,646.18			
36578	REPLACE TUNNELED CV CATH		5,241.41	4,907.68			
36580	REPLACE CVAD CATH		3,087.37	2,646.18			

36584	REPLACE PICC CATH		3,087.37	2,646.18			
36589	REMOVE TUNNELED CV CATH		1,718.86	1,473.23			
36592	COLLECT BLOOD PICC		171.82	147.27			
36593	DECLOT VASCULAR DEVICE		637.44	546.35			
36598	INJECT W/FLUOR, EVAL CV DEVICE		637.44	546.35			
36600	WITHDRAW ARTERIAL BLOOD		72.62	62.24			
36620	INSERT CATHETER, ARTERY					N1	
36625	INSERT CATHETER, ARTERY					N1	
36800	INSERT CANNULA		8,505.69	7,354.12			
36810	INSERT CANNULA		8,505.69	7,354.12			
36815	INSERT CANNULA		8,505.69	7,354.12			
36818	AV FUSE, UPPER ARM, CEPHALIC		11,329.30	9,710.33			
36833	AV FISTULA REVISION		11,329.30	9,710.33			
36860	EXTERNAL CANNULA DECLOTTING		637.44	546.35			
37204	TRANSCATHETER OCCLUSION		19,232.98	16,856.39			
37609	TEMPORAL ARTERY PROCEDURE		4,909.21	4,207.68			
37620	REVISE MAJOR VEIN		11,946.47	10,239.31			
37650	REVISE MAJOR VEIN		7,454.87	6,389.56			
38200	INJECTION FOR SPLEEN X-RAY					N1	
43235	UPPER GI ENDOSCOPY, DIAGNOSIS		2,411.81	2,067.16			
43236	UPPER GI SCOPE W/SUBMUCOSA INJECT		2,411.81	2,067.16			
43239	UPPER GI ENDOSCOPY, BIOPSY		2,411.81	2,067.16			
43246	PLACE GASTROSTOMY TUBE		2,411.81	2,067.16			
43248	UPPER GI ENDOSCOPY/GUIDE WIRE		2,411.81	2,067.16			
43249	ESOPH ENDOSCOPY, DILATION		2,411.81	2,067.16			
43255	OPERATIVE UPPER GI ENDOSCOPY		2,411.81	2,067.16			
43259	ENDOSCOPIC ULTRASOUND EXAM		2,411.81	2,067.16			
43260	ENDO CHOLANGIOPANCREATOGRAPHY		6,309.66	5,408.00			
43450	DILATE ESOPHAGUS		1,782.37	1,527.67			
43760	CHANGE GASTROSTOMY TUBE		637.44	546.35			
43830	PLACE GASTROSTOMY TUBE		4,529.06	3,881.86			
44500	INTRODUCE GASTROINTESTINAL TUBE		1,718.86	1,473.23			
46040	INCISE RECTAL ABSCESS		6,610.91	5,666.21			
46600	DIAGNOSTIC ANOSCOPY		182.27	156.22			AS
47000	NEEDLE BIOPSY LIVER		2,643.63	2,265.85			
49080	PUNCTURE, PERITONEAL CAVITY		1,510.65	1,294.77			
49320	DIAG LAP SEPARATE PROC		10,495.79	8,995.94			
49421	INSERT ABDOM DRAIN, PERM		7,481.94	6,471.31			
49505	PART RPR I/HERNIA INIT REDUCT >5 YR		8,982.66	7,699.03			
50392	INSERT KIDNEY DRAIN		4,772.16	4,090.22			
50394	INJECTION FOR KIDNEY X-RAY					N1	
51600	INJECTION FOR BLADDER X-RAY					N1	
51610	INJECTION FOR BLADDER X-RAY					N1	
51700	IRRIGATION BLADDER		553.11	474.07			
51701	INSERT BLADDER CATHETER		182.27	156.22			AS
51702	INSERT TEMP BLADDER CATH		182.27	156.22			AS
51703	INSERT BLADDER CATH, COMPLEX		301.69	258.58			
51705	CHANGE BLADDER TUBE		553.11	474.07			

51720	TREAT BLADDER LESION		872.10	747.48			
51725	SIMPLE CYSTOMETROGRAM		872.10	747.48			
51726	COMPLEX CYSTOMETROGRAM		872.10	747.48			
51741	ELECTRO-UROFLOWMETRY, FIRST		301.69	258.58			
51784	ANAL/URINARY MUSCLE STUDY		301.69	258.58			
51797	INTRAABDOMINAL PRESSURE TEST		553.11	474.07			
51798	US URINE CAPACITY MEASURE		182.27	156.22			AS
52000	CYSTOSCOPY		2,020.50	1,731.77			
52005	CYSTOSCOPY & URETER CATHETER		7,150.85	6,128.99			
52204	CYSTOSCOPY W/BIOPSY(S)		7,150.85	6,128.99			
52281	CYSTOSCOPY & TREAT		4,772.16	4,090.22			
52310	CYSTOSCOPY & TREAT		4,772.16	4,090.22			
52332	CYSTOSCOPY & TREAT		7,150.85	6,128.99			
52351	CYSTOURETERO & OR PYELOSCOPE		7,150.85	6,128.99			
53600	DILATE URETHRA STRICTURE		874.07	749.17			
53601	DILATE URETHRA STRICTURE		301.69	258.58			
53660	DILATE URETHRA		301.69	258.58			
53661	DILATE URETHRA		301.69	258.58			
54235	PENILE INJECTION		872.10	747.48			
57452	EXAM CERVIX W/SCOPE		443.98	380.53			
57500	BIOPSY CERVIX		1,783.00	1,528.21			
57511	CRYOCAUTERY CERVIX		443.98	380.53			
58340	CATHETER FOR HYSTERORRHAPHY					N1	
58558	HYSTEROSCOPY, BIOPSY		6,268.18	5,372.45			
59000	AMNIOCENTESIS, DIAGNOSTIC		983.13	842.64			
59025	FETAL NON-STRESS TEST		443.98	380.53			
59841	ABORTION		5,615.09	4,812.69			
61790	TREAT TRIGEMINAL NERVE		5,195.44	4,453.01			
62263	EPIDURAL LYSIS MULT SESSIONS		2,060.68	1,766.21			
62264	EPIDURAL LYSIS ON SINGLE DAY		3,474.53	2,978.02			
62270	SPINAL FLUID TAP, DIAGNOSTIC		1,054.25	903.60			
62273	INJECT EPIDURAL PATCH		2,060.68	1,766.21			
62280	TREAT SPINAL CORD LESION		2,060.68	1,766.21			
62281	TREAT SPINAL CORD LESION		2,060.68	1,766.21			
62282	TREAT SPINAL CANAL LESION		2,060.68	1,766.21			
62284	INJECTION FOR MYELOGRAM					N1	
62287	PERCUTANEOUS DISKECTOMY		10,121.96	8,675.52			
62290	INJECT FOR SPINE DISK X-RAY					N1	
62291	INJECT FOR SPINE DISK X-RAY					N1	
62292	INJECTION INTO DISK LESION		2,060.68	1,766.21			
62310	INJECT SPINE C/T		2,060.68	1,766.21			
62311	INJECT SPINE L/S (CD)		2,060.68	1,766.21			
62318	INJECT SPINE W/CATH, C/T		2,060.68	1,766.21			
62319	INJECT SPINE W/CATH L/S (CD)		3,474.53	2,978.02			
62350	IMPLANT SPINAL CANAL CATH		11,382.48	9,755.92			
62355	REMOVE SPINAL CANAL CATHETER		3,474.53	2,978.02			
62360	INSERT SPINE INFUSION DEVICE		11,382.48	9,755.92			
62362	IMPLANT SPINE INFUSION PUMP		22,227.97	20,941.63			

62365	REMOVE SPINE INFUSION DEVICE		10,121.96	8,675.52			
62367	ANALYZE SPINE INFUSION PUMP		657.70	563.72	X		
62368	ANALYZE SPINE INFUSION PUMP		657.70	563.72	X		
63020	NECK SPINE DISK SURG		13,940.72	11,948.58			
63030	LOW BACK DISK SURG		13,940.72	11,948.58			
63035	SPINAL DISK SURG, ADDED		13,940.72	11,948.58			
63040	LAMINOTOMY, SINGLE CERV		13,940.72	11,948.58			
63042	LAMINOTOMY, SINGLE LUMBAR		13,940.72	11,948.58			
63045	REMOVE SPINAL LAMINA		13,940.72	11,948.58			
63046	REMOVE SPINAL LAMINA		13,940.72	11,948.58			
63047	REMOVE SPINAL LAMINA		13,940.72	11,948.58			
63048	REMOVE SPINAL LAMINA, ADDED		13,940.72	11,948.58			
63056	DECOMPRESS SPINAL CORD		13,940.72	11,948.58			
63057	DECOMPRESS SPINE CORD, ADDED		13,940.72	11,948.58			
63075	NECK SPINE DISK SURG		13,940.72	11,948.58			
63076	NECK SPINE DISK SURG		13,940.72	11,948.58			
63650	IMPLANT NEUROELECTRODES		17,950.74	9,545.51	X		
63655	IMPLANT NEUROELECTRODES		13,352.79	12,138.59	X		
63685	INSERT/REDO SPINE N GENERATOR		23,191.56	22,061.87	X		
63688	REVISE/REMOVE NEURORECEIVER		7,898.33	6,769.65			
64400	NERVE BLOCK INJ, TRIGEMINAL		724.57	621.03			
64402	NERVE BLOCK INJ, FACIAL		724.57	621.03			
64405	NERVE BLOCK INJ, OCCIPITAL		1,054.25	903.60			
64412	NERVE BLOCK INJ, SPINAL ACCESSORY		2,060.68	1,766.21			
64413	NERVE BLOCK INJ, CERV PLEXUS		1,054.25	903.60			
64415	NERVE BLOCK INJ, BRACHIAL PLEXUS		1,054.25	903.60			
64416	NERVE BLOCK CONT INFUSE, B PLEX		2,060.68	1,766.21			
64417	NERVE BLOCK INJ, AXILLARY		1,054.25	903.60			
64418	NERVE BLOCK INJ, SUPRASCAPULAR		1,054.25	903.60			
64420	NERVE BLOCK INJ, INTERCOSTAL, SING		1,054.25	903.60			
64421	NERVE BLOCK INJ, INTERCOSTAL, MULT		2,060.68	1,766.21			
64425	NERVE BLOCK INJ, ILIO-ING/HYPOGI		1,054.25	903.60			
64430	NERVE BLOCK INJ, PUDENDAL		2,060.68	1,766.21			
64435	NERVE BLOCK INJ, PARACERV		1,054.25	903.60			
64445	NERVE BLOCK INJ, SCIATIC, SING		2,060.68	1,766.21			
64446	NERVE BLOCK INJ, SCIATIC, CONT INF		2,060.68	1,766.21			
64447	NERVE BLOCK INJ, FEM, SING		1,054.25	903.60			
64448	NERVE BLOCK INJ, FEM, CONT INF		2,060.68	1,766.21			
64449	NERVE BLOCK INJ, LUMBAR PLEXUS		2,060.68	1,766.21			
64450	NERVE BLOCK, OTHER PERIPHERAL		1,054.25	903.60			
64455	NERVE BLOCK INJ, PLANTAR DIGIT		724.57	621.03			
64479	INJECT FORAMEN EPIDURAL C/T		2,060.68	1,766.21			
64480	INJECT FORAMEN EPIDURAL, ADDED		1,054.25	903.60			
64483	INJECT FORAMEN EPIDURAL L/S		2,060.68	1,766.21			
64484	INJECT FORAMEN EPIDURAL, ADDED		1,054.25	903.60			
64490	INJECT PARAVERT F JNT C/T 1 LEV		2,060.68	1,766.21			
64491	INJECT PARAVERT F JNT C/T 2 LEV		724.57	621.03			
64492	INJECT PARAVERT F JNT C/T 3 LEV		724.57	621.03			

64493	INJECT PARAVERT F JNT L/S 1 LEV		2,060.68	1,766.21			
64494	INJECT PARAVERT F JNT L/S 2 LEV		724.57	621.03			
64495	INJECT PARAVERT F JNT L/S 3 LEV		724.57	621.03			
64505	NERVE BLOCK SPHENOPALATINE GANGLIA		724.57	621.03			
64510	NERVE BLOCK STELLATE GANGLION		2,060.68	1,766.21			
64517	NERVE BLOCK INJ, HYPOGAS PLXS		2,060.68	1,766.21			
64520	NERVE BLOCK LUMBAR/THORACIC		2,060.68	1,766.21			
64555	IMPLANT NEUROELECTRODES		10,600.82	9,545.51	X		
64561	IMPLANT NEUROELECTRODES		10,600.82	9,545.51	X		
64565	IMPLANT NEUROELECTRODES		10,600.82	9,545.51	X		
64600	INJECTION TREAT NERVE		3,474.53	2,978.02			
64605	INJECTION TREAT NERVE		5,195.44	4,453.01			
64610	INJECTION TREAT NERVE		5,195.44	4,453.01			
64612	DESTROY NERVE, FACE MUSCLE		724.57	621.03			
64613	DESTROY NERVE, NECK MUSCLE		1,054.25	903.60			
64614	DESTROY NERVE, EXTREMITY MUSC		1,054.25	903.60			
64620	INJECTION TREAT NERVE		2,060.68	1,766.21			
64622	DESTROY PARAVERTEBRAL NERVE L/S		3,474.53	2,978.02			
64623	DESTROY PARAVERT NERVE, ADDED		2,060.68	1,766.21			
64626	DESTROY PARAVERTEBRAL NERVE C/T		2,060.68	1,766.21			
64627	DESTROY PARAVERT NERVE, ADDED		724.57	621.03			
64640	INJECTION TREAT NERVE		2,060.68	1,766.21			
64680	INJECTION TREAT NERVE		2,060.68	1,766.21			
64702	REVISE FINGER/TOE NERVE		5,195.44	4,453.01			
64704	REVISE HAND/FOOT NERVE		5,195.44	4,453.01			
64708	REVISE ARM/LEG NERVE		5,195.44	4,453.01			
64712	REVISE SCIATIC NERVE		5,195.44	4,453.01			
64713	REVISE ARM NERVE(S)		5,195.44	4,453.01			
64714	REVISE LOW BACK NERVE(S)		5,195.44	4,453.01			
64716	REVISE CRANIAL NERVE		5,195.44	4,453.01			
64718	REVISE ULNAR NERVE AT ELBOW		5,195.44	4,453.01			
64719	REVISE ULNAR NERVE AT WRIST		5,195.44	4,453.01			
64721	CARPAL TUNNEL SURG		5,195.44	4,453.01			
65205	REMOVE FOREIGN BODY EYE		263.33	225.70	X		
65210	REMOVE FOREIGN BODY EYE		263.33	225.70	X		
65220	REMOVE FOREIGN BODY EYE		263.33	225.70	X		
65222	REMOVE FOREIGN BODY EYE		263.33	225.70	X		
65265	REMOVE FOREIGN BODY EYE		6,362.61	5,453.39			
67412	EXPLORE/TREAT EYE SOCKET		5,433.49	4,657.04			
69210	REMOVE IMPACTED EAR WAX		182.27	156.22			AS
69310	REBUILD OUTER EAR CANAL		12,135.56	10,401.38			
69320	REBUILD OUTER EAR CANAL		12,135.56	10,401.38			
69666	REPAIR MIDDLE EAR STRUCTURES		12,135.56	10,401.38			
69667	REPAIR MIDDLE EAR STRUCTURES		12,135.56	10,401.38			
69990	MICROSURG, ADDED					N1	
70030	X-RAY EYE FOR FOREIGN BODY		177.57	152.20			AS
70100	X-RAY JAW < 4 VIEWS		177.57	152.20			AS
70110	X-RAY JAW MINIMUM 4 VIEWS		177.57	152.20			AS

70120	X-RAY MASTOIDS < 3 VIEWS/SIDE		177.57	152.20			AS
70130	X-RAY MASTOIDS MINIMUM 3 VIEWS/SIDE		177.57	152.20			AS
70140	X-RAY FACIAL BONES < 3 VIEWS		177.57	152.20			AS
70150	X-RAY FACIAL BONES MINIMUM 3 VIEWS		177.57	152.20			AS
70160	X-RAY NASAL BONES MINIMUM 3 VIEWS		177.57	152.20			AS
70190	X-RAY OPTIC FORAMINA		177.57	152.20			AS
70200	X-RAY ORBITS, MINIMUM 4 VIEWS		177.57	152.20			AS
70210	X-RAY SINUSES < 3 VIEWS		177.57	152.20			AS
70220	X-RAY SINUSES MINIMUM 3 VIEWS		177.57	152.20			AS
70250	X-RAY SKULL < 4 VIEWS		177.57	152.20			AS
70260	X-RAY SKULL MINIMUM 4 VIEWS		299.09	256.35			AS
70300	X-RAY TEETH SINGLE VIEW		120.17	103.00			AS
70310	X-RAY TEETH < FULL MOUTH		120.17	103.00			AS
70320	X-RAY TEETH FULL MOUTH		120.17	103.00			AS
70328	X-RAY TMJ UNILATERAL		177.57	152.20			AS
70330	X-RAY TMJ BILATERAL		177.57	152.20			AS
70332	TMJ ARTHOGRAPHY; RAD SUPER & INTERP		1,084.37	929.42			
70336	MRI TMJ		1,352.04	1,158.83			
70350	CEPHALOGRAM, ORTHODONTIC		177.57	152.20			AS
70355	ORTHOPANTOGRAM		120.17	103.00			AS
70360	X-RAY NECK SOFT TISSUE		177.57	152.20			AS
70450	CT HEAD/BRAIN W/O DYE		764.27	655.06			
70460	CT HEAD/BRAIN W/DYE		1,182.03	1,013.12			
70470	CT HEAD/BRAIN W/O & W/DYE		1,317.77	1,129.46			
70480	CT ORBIT/EAR/FOSSA W/O DYE		764.27	655.06			
70481	CT ORBIT/EAR/FOSSA W/DYE		1,182.03	1,013.12			
70482	CT ORBIT/EAR/FOSSA W/O & W/DYE		1,317.77	1,129.46			
70486	CT MAXILLOFACIAL W/O DYE		764.27	655.06			
70487	CT MAXILLOFACIAL W/DYE		1,182.03	1,013.12			
70488	CT MAXILLOFACIAL W/O & W/DYE		1,317.77	1,129.46			
70490	CT SOFT TISSUE NECK W/O DYE		764.27	655.06			
70491	CT SOFT TISSUE NECK W/DYE		1,182.03	1,013.12			
70492	CT SOFT TISSUE NECK W/O & W/DYE		1,317.77	1,129.46			
70496	CT ANGIOGRAPHY, HEAD		1,334.69	1,143.96			
70498	CT ANGIOGRAPHY, NECK		1,334.69	1,143.96			
70540	MRI ORBIT/FACE/NECK W/O DYE		1,352.04	1,158.83			
70542	MRI ORBIT/FACE/NECK W/DYE		1,722.84	1,476.64			
70543	MRI ORBIT/FACE/NECK W/O & W/DYE		2,103.77	1,803.14			
70544	MR ANGIOGRAPHY HEAD W/O DYE		1,352.04	1,158.83			
70545	MR ANGIOGRAPHY HEAD W/DYE		1,722.84	1,476.64			
70546	MR ANGIOGRAPH HEAD W/O & W/DYE		2,103.77	1,803.14			
70547	MR ANGIOGRAPHY NECK W/O DYE		1,352.04	1,158.83			
70548	MR ANGIOGRAPHY NECK W/DYE		1,722.84	1,476.64			
70549	MR ANGIOGRAPH NECK W/O & W/DYE		2,103.77	1,803.14			
70551	MRI BRAIN W/O DYE		1,352.04	1,158.83			
70552	MRI BRAIN W/DYE		1,722.84	1,476.64			
70553	MRI BRAIN W/O & W/DYE		2,103.77	1,803.14			
70554	FMRI BRAIN BY TECH		1,352.04	1,158.83			

70555	FMRI BRAIN BY PHYS/PSYCH		1,352.04	1,158.83	X		
71010	CHEST X-RAY SINGLE VIEW FRONTAL		177.57	152.20			
71020	CHEST X-RAY 2 VIEWS FRONTAL & LATERAL		177.57	152.20			
71021	CHEST X-RAY 2 VIEWS W/APICAL LORD PROC		177.57	152.20			AS
71022	CHEST X-RAY 2 VIEWS W/OBLIQUE PROJ		177.57	152.20			AS
71030	CHEST X-RAY MINIMUM 4 VIEWS		177.57	152.20			AS
71035	CHEST X-RAY SPECIAL VIEWS		177.57	152.20			AS
71040	CONTRAST X-RAY BRONCHI UNILATERAL		906.64	777.08			
71090	X-RAY & PACEMAKER INSERT					N1	
71100	X-RAY RIBS 2 VIEWS		177.57	152.20			AS
71101	X-RAY RIBS/CHEST MINIMUM 3 VIEWS		177.57	152.20			AS
71110	X-RAY RIBS BILATERAL 3 VIEWS		177.57	152.20			AS
71111	X-RAY RIBS/CHEST MINIMUM 4 VIEWS		299.09	256.35			AS
71120	X-RAY STERNUM MINIMUM 2 VIEWS		177.57	152.20			AS
71130	X-RAY STERNOCLAV JOINT MINIMUM 3 VIEWS		177.57	152.20			AS
71250	CT THORAX W/O DYE		764.27	655.06			
71260	CT THORAX W/DYE		1,182.03	1,013.12			
71270	CT THORAX W/O & W/DYE		1,317.77	1,129.46			
71275	CT ANGIOGRAPHY, CHEST		1,334.69	1,143.96			
71550	MRI CHEST W/O DYE		1,352.04	1,158.83			
71552	MRI CHEST W/O & W/DYE		2,103.77	1,803.14			
72010	X-RAY SPINE ANTEROPOST & LATERAL		299.09	256.35			AS
72020	X-RAY SPINE SINGLE VIEW SPECIFY LEVEL		177.57	152.20			AS
72040	X-RAY NECK SPINE CERV 2/3 VIEWS		177.57	152.20			AS
72050	X-RAY NECK SPINE CERV MINIMUM 4 VIEWS		299.09	256.35			AS
72052	X-RAY NECK SPINE COMPLETE		299.09	256.35			AS
72069	X-RAY TRUNK SPINE STANDING		177.57	152.20			AS
72070	X-RAY THORACIC SPINE 2 VIEWS		177.57	152.20			AS
72072	X-RAY THORACIC SPINE 3 VIEWS		177.57	152.20			AS
72074	X-RAY THORACIC SPINE MINIMUM 4 VIEWS		177.57	152.20			AS
72080	X-RAY TRUNK SPINE 2 VIEWS		177.57	152.20			AS
72090	X-RAY TRUNK SPINE SCOLIOSIS STUDY		299.09	256.35			AS
72100	X-RAY LOWER SPINE 2/3 VIEWS		177.57	152.20			AS
72110	X-RAY LOWER SPINE MINIMUM 4 VIEWS		299.09	256.35			AS
72114	X-RAY LOWER SPINE COMPLETE		299.09	256.35			AS
72120	X-RAY LOWER SPINE BENDING MINIMUM 4 VIEWS		177.57	152.20			AS
72125	CT NECK SPINE W/O DYE		764.27	655.06			
72126	CT NECK SPINE W/DYE		1,182.03	1,013.12			
72127	CT NECK SPINE W/O & W/DYE		1,317.77	1,129.46			
72128	CT CHEST SPINE W/O DYE		764.27	655.06			
72129	CT CHEST SPINE W/DYE		1,182.03	1,013.12			
72130	CT CHEST SPINE W/O & W/DYE		1,317.77	1,129.46			
72131	CT LUMBAR SPINE W/O DYE		764.27	655.06			
72132	CT LUMBAR SPINE W/DYE		1,182.03	1,013.12			
72133	CT LUMBAR SPINE W/O & W/DYE		1,317.77	1,129.46			
72141	MRI NECK SPINE W/O DYE		1,352.04	1,158.83			
72142	MRI NECK SPINE W/DYE		1,722.84	1,476.64			
72146	MRI CHEST SPINE W/O DYE		1,352.04	1,158.83			

72147	MRI CHEST SPINE W/DYE		1,722.84	1,476.64			
72148	MRI LUMBAR SPINE W/O DYE		1,352.04	1,158.83			
72149	MRI LUMBAR SPINE W/DYE		1,722.84	1,476.64			
72156	MRI NECK SPINE W/O & W/DYE		2,103.77	1,803.14			
72157	MRI CHEST SPINE W/O & W/DYE		2,103.77	1,803.14			
72158	MRI LUMBAR SPINE W/O & W/DYE		2,103.77	1,803.14			
72170	X-RAY PELVIS 1/2 VIEWS		177.57	152.20			AS
72190	X-RAY PELVIS MINIMUM 3 VIEWS		177.57	152.20			AS
72191	CT ANGIOGRAPH PELVIS W/O & W/DYE		1,334.69	1,143.96			
72192	CT PELVIS W/O DYE		764.27	655.06			
72193	CT PELVIS W/DYE		1,182.03	1,013.12			
72194	CT PELVIS W/O & W/DYE		1,317.77	1,129.46			
72195	MRI PELVIS W/O DYE		1,352.04	1,158.83			
72196	MRI PELVIS W/DYE		1,722.84	1,476.64			
72197	MRI PELVIS W/O & W/DYE		2,103.77	1,803.14			
72200	X-RAY EXAM SACROILIAC JOINTS		177.57	152.20			AS
72202	X-RAY EXAM SACROILIAC JOINTS		177.57	152.20			AS
72220	X-RAY TAILBONE		177.57	152.20			AS
72240	CONTRAST X-RAY NECK SPINE		1,967.75	1,686.56			
72255	CONTRAST X-RAY THORAX SPINE		1,967.75	1,686.56			
72265	CONTRAST X-RAY LOWER SPINE		1,967.75	1,686.56			
72270	CONTRAST X-RAY SPINE		1,967.75	1,686.56			
72275	EPIDUROGRAPHY					N1	
72285	X-RAY C/T SPINE DISK		6,593.09	5,650.93			
72291	PERCUT VERT/SACROPLASTY, FLUOR					N1	
72295	X-RAY LOWER SPINE DISK		6,593.09	5,650.93			
73000	X-RAY COLLAR BONE		177.57	152.20			AS
73010	X-RAY SHOULDER BLADE		177.57	152.20			AS
73020	X-RAY SHOULDER 1 VIEW		177.57	152.20			AS
73030	X-RAY SHOULDER MINIMUM 2 VIEWS		177.57	152.20			AS
73040	CONTRAST X-RAY SHOULDER		1,084.37	929.42			
73050	X-RAY SHOULDERS		177.57	152.20			AS
73060	X-RAY HUMERUS MINIMUM 2 VIEWS		177.57	152.20			AS
73070	X-RAY ELBOW 2 VIEWS		177.57	152.20			AS
73080	X-RAY ELBOW MINIMUM 3 VIEWS		177.57	152.20			AS
73090	X-RAY FOREARM		177.57	152.20			AS
73092	X-RAY ARM, INFANT		177.57	152.20			AS
73100	X-RAY WRIST 2 VIEWS		177.57	152.20			AS
73110	X-RAY WRIST MINIMUM 3 VIEWS		177.57	152.20			AS
73115	CONTRAST X-RAY WRIST		1,084.37	929.42			
73120	X-RAY HAND 2 VIEWS		177.57	152.20			AS
73130	X-RAY HAND MINIMUM 3 VIEWS		177.57	152.20			AS
73140	X-RAY FINGER(S) MINIMUM 2 VIEWS		177.57	152.20			AS
73200	CT UPPER EXTREMITY W/O DYE		764.27	655.06			
73201	CT UPPER EXTREMITY W/DYE		1,182.03	1,013.12			
73202	CT UPPER EXTREMITY W/O & W/DYE		1,317.77	1,129.46			
73206	CT ANGIO UPR EXTREMITY W/O & W/DYE		1,334.69	1,143.96			
73218	MRI UPPER EXTREMITY W/O DYE		1,352.04	1,158.83			

73219	MRI UPPER EXTREMITY W/DYE		1,722.84	1,476.64			
73220	MRI UPPER EXTREMITY W/O & W/DYE		2,103.77	1,803.14			
73221	MRI JOINT UPPER EXTREMITY W/O DYE		1,352.04	1,158.83			
73222	MRI JOINT UPPER EXTREMITY W/DYE		1,722.84	1,476.64			
73223	MRI JOINT UPPER EXTREMITY W/O & W/DYE		2,103.77	1,803.14			
73500	X-RAY HIP UNILATERAL 1 VIEW		177.57	152.20			AS
73510	X-RAY HIP COMPLETE MINIMUM 2 VIEWS		177.57	152.20			AS
73520	X-RAY HIPS MINIMUM 2 VIEWS		177.57	152.20			AS
73525	X-RAY HIP ARTHROGRAPHY		1,084.37	929.42			
73530	X-RAY HIP DURING OPERATIVE PROCEDURE					N1	
73540	X-RAY PELVIS & HIPS MINIMUM 2 VIEWS		177.57	152.20			AS
73542	X-RAY EXAM, SACROILIAC JOINT		1,084.37	929.42			
73550	X-RAY THIGH 2 VIEWS		177.57	152.20			AS
73560	X-RAY KNEE 1/2 VIEWS		177.57	152.20			AS
73562	X-RAY KNEE 3 VIEWS		177.57	152.20			AS
73564	X-RAY KNEE, COMPLETE 4/MORE VIEWS		177.57	152.20			AS
73565	X-RAY KNEES STANDING ANTEROPOST		177.57	152.20			AS
73580	X-RAY KNEE ARTHOGRAPHY		1,084.37	929.42			
73590	X-RAY TIBIA & FIBULA 2 VIEWS		177.57	152.20			AS
73592	X-RAY LEG, INFANT MINIMUM 2 VIEWS		177.57	152.20			AS
73600	X-RAY ANKLE 2 VIEWS		177.57	152.20			AS
73610	X-RAY ANKLE MINIMUM 3 VIEWS		177.57	152.20			AS
73615	CONTRAST X-RAY ANKLE		1,084.37	929.42			
73620	X-RAY FOOT 2 VIEWS		177.57	152.20			AS
73630	X-RAY FOOT MINIMUM 3 VIEWS		177.57	152.20			AS
73650	X-RAY HEEL		177.57	152.20			AS
73660	X-RAY TOE(S)		177.57	152.20			AS
73700	CT LOWER EXTREMITY W/O DYE		764.27	655.06			
73701	CT LOWER EXTREMITY W/DYE		1,182.03	1,013.12			
73706	CT ANGIO LWR EXTREMITY W/O & W/DYE		1,334.69	1,143.96			
73718	MRI LOWER EXTREMITY W/O DYE		1,352.04	1,158.83			
73719	MRI LOWER EXTREMITY W/DYE		1,722.84	1,476.64			
73720	MRI LOWER EXTREMITY W/O & W/DYE		2,103.77	1,803.14			
73721	MRI JOINT LOWER EXTREMITY W/O DYE		1,352.04	1,158.83			
73722	MRI JOINT LOWER EXTREMITY W/DYE		1,722.84	1,476.64			
73723	MRI JOINT LWR EXTREMITY W/O & W/DYE		2,103.77	1,803.14			
74000	X-RAY ABDOMEN SINGLE ANTEROPOST		177.57	152.20			AS
74010	X-RAY ABDOMEN ANTEROPOST & ADDED VW		177.57	152.20			AS
74020	X-RAY ABDOMEN COMPLETE		177.57	152.20			AS
74022	X-RAY EXAM SERIES, ABDOMEN		299.09	256.35			AS
74150	CT ABDOMEN W/O DYE		764.27	655.06			
74160	CT ABDOMEN W/DYE		1,182.03	1,013.12			
74170	CT ABDOMEN W/O & W/DYE		1,317.77	1,129.46			
74175	CT ANGIO ABDOM W/O & W/DYE		1,334.69	1,143.96			
74176	CT ANGIO ABDOM & PELVIS		764.27	655.06			
74177	CT ANGIO ABDOM & PELVIS W/CONTRAST		1,182.03	1,013.12			
74178	CT ANGIO ABDOM & PELVIS 1+ REGNS		1,317.77	1,129.46			
74181	MRI ABDOMEN W/O DYE		1,352.04	1,158.83			

74183	MRI ABDOMEN W/O & W/DYE		2,103.77	1,803.14			
74220	CONTRAST X-RAY, ESOPHAGUS		341.90	293.04	X		
74230	CINE/VIDEO X-RAY, THROAT/ESOPH		341.90	293.04	X		
74241	X-RAY EXAM, UPPER GI TRACT W/KUB		341.90	293.04	X		
74246	CONTRAST X-RAY UGI TRACT W/O KUB		341.90	293.04	X		
74280	CONTRAST X-RAY COLON W/WO GLUCOGEN		559.77	479.78	X		
74290	CONTRAST X-RAY, GALLBLADDER		341.90	293.04	X		
74330	X-RAY BILE/PANCREAS ENDOSCOPY					N1	
74400	CONTRAST X-RAY URINARY TRACT		694.37	595.14	X		
74410	CONTRAST X-RAY URINARY TRACT		694.37	595.14	X		
74415	CONTRAST X-RAY URINARY TRACT		694.37	595.14	X		
74420	CONTRAST X-RAY URINARY TRACT		694.37	595.14	X		
74425	CONTRAST X-RAY URINARY TRACT		694.37	595.14			
74430	CONTRAST X-RAY BLADDER		694.37	595.14			
74450	X-RAY URETHRA/BLADDER		694.37	595.14			
74455	X-RAY URETHRA/BLADDER		694.37	595.14			
74475	X-RAY CONTROL, CATH INSERT		4,772.16	4,090.22			
74480	X-RAY CONTROL, CATH INSERT		4,772.16	4,090.22			
74485	X-RAY GUIDE, GU DILATION		4,772.16	4,090.22			
75561	CARDIAC MRI FOR MORPH W/DYE		2,103.77	1,803.14			
75572	CT HEART W/3D IMAGE		1,012.70	867.98	X		
75574	CT ANGIO HEART W/3D IMAGE		1,012.70	867.98	X		
75605	CONTRAST X-RAY AORTA		7,990.03	6,848.25			
75625	CONTRAST X-RAY AORTA		7,990.03	6,848.25			
75630	X-RAY AORTA, LEG ARTERIES		7,990.03	6,848.25			
75635	CT ANGIO ABDOMINAL ARTERIES		1,334.69	1,143.96			
75650	ARTERY X-RAYS HEAD & NECK		12,970.25	11,116.79			
75665	ARTERY X-RAYS HEAD & NECK		7,990.03	6,848.25			
75671	ARTERY X-RAYS HEAD & NECK		12,970.25	11,116.79			
75676	ARTERY X-RAYS NECK UNILATERAL		7,990.03	6,848.25			
75680	ARTERY X-RAYS NECK BILATERAL		7,990.03	6,848.25			
75685	ARTERY X-RAYS SPINE		7,990.03	6,848.25			
75705	ARTERY X-RAYS SPINE		7,990.03	6,848.25			
75710	ARTERY X-RAYS ARM/LEG		7,990.03	6,848.25			
75716	ARTERY X-RAYS ARMS/LEGS		7,990.03	6,848.25			
75722	ARTERY X-RAYS KIDNEY		7,990.03	6,848.25			
75724	ARTERY X-RAYS KIDNEYS		7,990.03	6,848.25			
75726	ARTERY X-RAYS ABDOMEN		7,990.03	6,848.25			
75736	ARTERY X-RAYS PELVIS		7,990.03	6,848.25			
75743	ARTERY X-RAYS LUNGS		7,990.03	6,848.25			
75774	ARTERY X-RAY, EACH VESSEL					N1	
75809	NONVASCULAR SHUNT, X-RAY		299.09	256.35			
75820	VEIN X-RAY ARM/LEG		2,833.55	2,428.63			
75822	VEIN X-RAY ARMS/LEGS		2,833.55	2,428.63			
75825	VEIN X-RAY TRUNK		7,990.03	6,848.25			
75894	X-RAYS, TRANSCATH THERAPY					N1	
75898	F/U ANGIOGRAPHY		299.09	256.35			
75940	X-RAY PLACE VEIN FILTER					N1	

75960	TRANSCATH IV STENT RS & I					N1	
75961	RETRIEVE BROKEN CATHETER					N1	
75962	REPAIR ARTERIAL BLOCKAGE		12,095.18	10,542.37			
75964	REPAIR ARTERY BLOCKAGE, EACH					N1	
75978	REPAIR VENOUS BLOCKAGE		8,317.24	7,228.17			
75984	X-RAY CONTROL CATHETER CHANGE					N1	
75989	ABSCESS DRAIN UNDER X-RAY					N1	
76000	FLUOROSCOPE EXAM		329.21	282.16			
76001	FLUOROSCOPE EXAM, EXTENSIVE					N1	
76010	X-RAY NOSE TO RECTUM		177.57	152.20			AS
76080	X-RAY FISTULA		906.64	777.08			
76098	X-RAY EXAM, BREAST SPECIMEN		1,605.07	1,375.71			
76100	X-RAY BODY SECTION		299.09	256.35			AS
76102	COMPLEX BODY SECTION X-RAYS		906.64	777.08			AS
76120	CINE/VIDEO X-RAYS		329.21	282.16			AS
76125	CINE/VIDEO X-RAYS, ADDED					N1	
76376	3D RENDER W/O POST PROCESS					N1	
76377	3D RENDERING W/POST PROCESS					N1	
76380	CAT SCAN F/U STUDY		447.45	383.51	X		
76506	ECHO EXAM HEAD		245.43	210.36	X		
76510	OPHTHALMIC US, B & QUANT A		691.93	593.05			
76511	OPHTHALMIC US, QUANT A ONLY		379.59	325.35	X		
76512	OPHTHALMIC US, B W/NON-QUANT A		379.59	325.35	X		
76514	ECHO EXAM EYE, THICKNESS		72.62	62.24			AS
76516	ECHO EXAM EYE		245.43	210.36	X		
76519	ECHO EXAM EYE		379.59	325.35	X		
76536	US EXAM HEAD & NECK		379.59	325.35	X		
76604	US EXAM, CHEST		245.43	210.36			
76645	US EXAM, BREAST(S)		245.43	210.36	X		
76700	US EXAM, ABDOM, COMPLETE		379.59	325.35			
76705	ECHO EXAM ABDOMEN		379.59	325.35			
76770	US EXAM ABDOM BACK WALL, COMP		379.59	325.35			
76775	US EXAM ABDOM BACK WALL, LIM		379.59	325.35			
76776	US EXAM K TRANSPLANT W/DOPPLER		379.59	325.35			
76800	US EXAM, SPINAL CANAL		379.59	325.35	X		
76801	OBSTET US < 14 WKS, SINGLE FETUS		379.59	325.35	X		
76805	OBSTET US >/= 14 WKS, SINGLE FETUS		379.59	325.35	X		
76810	OBSTET US >/= 14 WKS, ADDED FETUS		379.59	325.35	X		
76811	OBSTET US, DETAILED, SINGLE FETUS		603.18	516.98	X		
76814	OBSTET US NUCHAL MEAS, ADDED		245.43	210.36	X		
76815	OBSTET US, LIMITED, FETUS(S)		245.43	210.36	X		
76816	OBSTET US, F/U, PER FETUS		245.43	210.36	X		
76817	TRANSVAGINAL US, OBSTETRIC		245.43	210.36	X		
76818	FETAL BIOPHYS PROFILE W/NST		379.59	325.35	X		
76819	FETAL BIOPHYS PROFILE W/O NST		379.59	325.35	X		
76820	UMBILICAL ARTERY ECHO		245.43	210.36	X		
76821	MIDDLE CEREBRAL ARTERY ECHO		245.43	210.36	X		
76826	ECHO EXAM FETAL HEART		1,586.46	1,359.76	X		

76827	ECHO EXAM FETAL HEART		245.43	210.36	X		
76828	ECHO EXAM FETAL HEART		245.43	210.36	X		
76830	TRANSVAGINAL US, NON-OB		379.59	325.35	X		
76856	US EXAM, PELVIC, COMPLETE		379.59	325.35			
76857	US EXAM, PELVIC, LIMITED		245.43	210.36			
76870	US EXAM, SCROTUM		379.59	325.35			
76872	US, TRANSRECTAL		379.59	325.35	X		
76881	US XTR NON-VASC COMPLETE		379.59	325.35	X		
76882	US XTR NON-VASC LMTD		245.43	210.36	X		
76937	US GUIDE VASCULAR ACCESS					N1	
76942	ECHO GUIDE FOR BIOPSY					N1	
76998	US GUIDE, INTRAOP					N1	
77001	FLUOROGUIDE FOR VEIN DEVICE					N1	
77002	NEEDLE LOCALIZATION BY X-RAY					N1	
77003	FLUOROGUIDE FOR SPINE INJECT					N1	
77011	CT SCAN FOR LOCALIZATION					N1	
77012	CT SCAN FOR NEEDLE BIOPSY					N1	
77032	GUIDANCE FOR NEEDLE, BREAST					N1	
77072	X-RAYS FOR BONE AGE		177.57	152.20			AS
77073	X-RAYS, BONE LENGTH STUDIES		177.57	152.20			AS
77074	X-RAYS, BONE SURVEY, LIMITED		299.09	256.35			AS
77075	X-RAYS, BONE SURVEY COMPLETE		299.09	256.35			AS
77076	X-RAYS, BONE SURVEY, INFANT		299.09	256.35			AS
77077	JOINT SURVEY, SINGLE VIEW		177.57	152.20			AS
77080	DIAG BONE DENSITY, AXIAL		278.03	238.30	X		
77081	DIAG BONE DENSITY/PERIPHERAL		126.60	108.51	X		
77082	DIAG BONE DENSITY, VERTEBRAL FX		177.57	152.20	X		
77280	SET RADIATION THERAPY FIELD		411.92	353.06			AS
77285	SET RADIATION THERAPY FIELD		1,070.85	917.82			AS
77290	SET RADIATION THERAPY FIELD		1,070.85	917.82			AS
77295	SET RADIATION THERAPY FIELD		3,653.77	3,131.64			AS
77300	RADIATION THERAPY DOSE PLAN		411.92	353.06			AS
77305	TELETX ISODOSE PLAN SIMPLE		411.92	353.06			AS
77310	TELETX ISODOSE PLAN INTERMED		411.92	353.06			AS
77315	TELETX ISODOSE PLAN COMPLEX		1,070.85	917.82			AS
77321	SPECIAL TELETX PORT PLAN		1,070.85	917.82			AS
77331	SPECIAL RADIATION DOSIMETRY		411.92	353.06			AS
77332	RADIATION TREAT AID(S)		787.38	674.86			AS
77333	RADIATION TREAT AID(S)		787.38	674.86			AS
77334	RADIATION TREAT AID(S)		787.38	674.86			AS
77336	RADIATION PHYSICS CONSULT		411.92	353.06			AS
77371	SRS, MULTISOURCE		30,204.85	25,888.56	X		
77403	RADIATION TX SING AREA 6-10MEV		385.67	330.55	X		
77413	RADIATION TX 3/MORE AREA 6-10MEV		632.95	542.50	X		
77414	RADIATION TX 3/MORE AREA 11-19MEV		632.95	542.50	X		
77417	RADIOLOGY PORT FILM(S)					N1	
77470	SPECIAL RADIATION TREAT		1,532.02	1,313.09	X		
78006	THYROID IMAGING W/UPTAKE		865.36	741.70	X		

78007	THYROID IMAGE, MULT UPTAKES		865.36	741.70	X		
78102	BONE MARROW IMAGING, LTD		1,013.33	868.52	X		
78103	BONE MARROW IMAGING, MULT		1,013.33	868.52	X		
78215	LIVER & SPLEEN IMAGING		1,045.30	895.93	X		
78220	LIVER FUNCTION STUDY		1,045.30	895.93	X		
78223	HEPATOBILIARY IMAGING		1,045.30	895.93	X		
78232	SALIVARY GLAND FUNCTION EXAM		943.46	808.64	X		
78300	BONE IMAGING, LIMITED AREA		964.75	826.89	X		
78305	BONE IMAGING, MULTIPLE AREAS		964.75	826.89	X		
78306	BONE IMAGING, WHOLE BODY		964.75	826.89	X		
78315	BONE IMAGING, 3 PHASE		964.75	826.89	X		
78320	BONE IMAGING (3D)		964.75	826.89	X		
78445	VASCULAR FLOW IMAGING		789.90	677.02	X		
78451	HEART MUSCLE IMAGE SPECT, SING		2,995.98	2,567.85	X		
78452	HEART MUSCLE IMAGE SPECT, MULT		2,995.98	2,567.85	X		
78469	HEART INFARCT IMAGE (3D)		1,148.83	984.67	X		
78472	GATED HEART, PLANAR, SING		1,148.83	984.67	X		
78481	HEART FIRST PASS, SING		1,148.83	984.67	X		
78494	HEART IMAGE, SPECT		1,148.83	984.67	X		
78580	LUNG PERFUSION IMAGING		776.02	665.13	X		
78584	LUNG V/Q IMAGE SINGLE BREATH		1,261.32	1,081.07	X		
78585	LUNG V/Q IMAGING		1,261.32	1,081.07	X		
78588	PERFUSION LUNG IMAGE		1,261.32	1,081.07	X		
78594	VENT IMAGE, MULT PROJ, GAS		776.02	665.13	X		
78596	LUNG DIFFERENTIAL FUNCTION		1,261.32	1,081.07	X		
78607	BRAIN IMAGING (3D)		2,350.85	2,014.92	X		
78707	KID FLOW/FUNCT IMAGE W/O DRUG		1,267.39	1,086.28	X		
78708	KID FLOW/FUNCT IMAGE W/DRUG		1,267.39	1,086.28	X		
78709	KIDNEY IMG MORPHOLOGY VASCULAR FLOW MULTIPLE		1,267.39	1,086.28	X		
78802	TUMOR IMAGING, WHOLE BODY		1,872.66	1,605.05	X		
78803	TUMOR IMAGING (3D)		1,872.66	1,605.05	X		
78805	ABSCESS IMAGING, LTD AREA		1,872.66	1,605.05	X		
78806	ABSCESS IMAGING, WHOLE BODY		1,872.66	1,605.05	X		
78815	PET IMAGE W/CT, SKULL-THIGH		4,108.15	3,521.09	X		
79101	NUCLEAR RX, IV ADMIN		883.62	757.35	X		
88141	CYTOPATH, C/V, INTERPRET					N1	
92070	FIT CONTACT LENS					N1	
92504	EAR MICROSCOPY EXAM					N1	
92547	SUPPLEMENTAL ELECTRICAL TEST					N1	
92621	AUDITORY FUNCTION, + 15 MIN					N1	
93314	ECHO TRANSESOPHAGEAL					N1	
93320	DOPPLER ECHO EXAM, HEART					N1	
93321	DOPPLER ECHO EXAM, HEART					N1	
93325	DOPPLER COLOR FLOW, ADDED					N1	
93463	DRUG ADMIN & HEMODYNMIC MEAS					N1	
93464	EXERCISE W/HEMODYNAMIC MEAS					N1	
93563	INJECT CONGENITAL CARD CATH					N1	
93564	INJECT HEART CONGNTL ART/GRAFT					N1	

93565	INJECT L VENTR/ATRIAL ANGIO					N1	
93566	INJECT R VENTR/ATRIAL ANGIO					N1	
93567	INJECT SUPRVLV AORTOGRAPHY					N1	
93568	INJECT PULM ART HEART CATH					N1	
93609	MAP TACHYCARDIA, ADDED					N1	
93623	STIMULATION, PACING HEART					N1	
93641	ELECTROPHYSIOLOGY EVAL					N1	
94760	MEASURE BLOOD OXYGEN LEVEL					N1	
94761	MEASURE BLOOD OXYGEN LEVEL					N1	
95873	GUIDE NERVE DESTROY, ELECT STIM					N1	
95874	GUIDE NERVE DESTROY, NEEDLE EMG					N1	
95920	INTRAOP NERVE TEST, ADDED					N1	
95955	EEG DURING SURG					N1	
95957	EEG DIGITAL ANALYSIS					N1	
96368	THER/DIAG CONCURRENT INF					N1	
99143	MOD SEDATION SAME PHYS, < 5 YRS					N1	
99144	MOD SEDATION BY SAME PHYS, 5 YRS +					N1	
99145	MOD SEDATION BY SAME PHYS, ADDED					N1	
99148	MOD SEDATION DIFF PHYS < 5 YRS					N1	
99149	MOD SEDATION DIFF PHYS 5 YRS +					N1	
99150	MOD SEDATION DIFF PHYS, ADDED					N1	
99175	INDUCTION VOMITING					N1	
99292	CRITICAL CARE, ADDED 30 MIN					N1	
99354	PROLONGED SERVICE, OFFICE					N1	
99355	PROLONGED SERVICE, OFFICE					N1	