ORDER NO. A12-114

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

IN THE MATTER OF THE REQUEST OF THE NEW JERSEY HEALTHCARE COALITION, THE ALLIANCE FOR QUALITY CARE, INC., THE NEW JERSEY ASSOCIATION OF AMBULATORY SURGERY CENTERS, THE NEW JERSEY ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS, NORTH JERSEY ORTHOPAEDIC SOCIETY, ATLANTIC ORTHOPEDIC ASSOCIATES, LLC, AND THE NEW JERSEY STATE SOCIETY OF ANESTHESIOLOGISTS FOR A STAY OF THE ADOPTION OF AMENDMENTS AND NEW RULES, N.J.A.C. 11:3-4.2, ET SEQ.	)	ORDER DENYING STAY PENDING APPEAL

This matter arises out of a request by the New Jersey Healthcare Coalition, the Alliance for Quality Care, Inc., the New Jersey Association of Ambulatory Surgery Centers, the New Jersey Association of Osteopathic Physicians and Surgeons, North Jersey Orthopaedic Society, Atlantic Orthopedic Associates, LLC, and the New Jersey State Society of Anesthesiologists, (hereafter referred to as "the Movants"), dated November 5, 2012, for a stay of the adoption of new rules, amendments and repeals concerning Personal Injury Protection (“PIP”) Benefits, PIP Dispute Resolution, and the PIP Fee Schedules for Physicians, Ambulatory Surgical Centers (“ASCs”), Hospital Outpatient Surgical Facilities (“HOSFs”), Dentists, Durable Medical Equipment, and Ambulance Services as adopted in 44 N.J.R. 2652(c) on November 5, 2012 (hereinafter generally as “the rules”), pending the Movants’ appeal of the adoption of the rules to the Appellate Division of the Superior Court.

The Notice of Adoption of the rules was published in the New Jersey Register on November 5, 2012 and, with the exception of certain amendments that will not become operative until November 5, 2013, will become operative on January 4, 2013. Prior to publishing the Notice of Proposal of the rules, the Department engaged in a lengthy advance notice of rulemaking process pursuant to Executive Order 2 which included the exchange of information and comments with interested parties, including medical providers and insurers. The proposal was published in the New Jersey Register at 43 N.J.R. 1640(a) on August 1, 2011, and more than 19,000 written comments were received. Subsequently, on February 21, 2012, a Notice of Proposed Substantial Changes Upon Adoption was published in the New Jersey Register at 44 N.J.R. 383(a) pursuant to N.J.S.A. 52:14B-4.10, and more than 300 comments were received on that Notice.

In support of their motion, the Movants state that the rules are unlawful and invalid as a matter of law because: (1) the rules violate the Legislature's specific mandate that the Personal Injury Protection ("PIP") fee schedule shall incorporate the reasonable and prevailing fees of 75 percent of the practitioners within the regions of the State; (2) the Commissioner of Banking and Insurance ("the Commissioner") exceeded his authority by providing in the fee schedules that certain procedures will not be reimbursed unless they are performed in hospitals or hospital outpatient surgical facilities ("HOSFs"); (3) the fee schedules provide for improperly low fees for ambulatory surgical centers ("ASCs") as compared to the fess provided for HOSFs for the same procedures; (4) the Commissioner exceeded his authority by adopting rules that impose restrictions on how PIP arbitrators may determine attorney's fee awards to successful claimants; and (5) the rules illegally provide that assignments of benefits to providers shall include both benefits and duties under the policy. The Movants assert that, based upon these purported

defects, they have a strong probability of success on their challenge to the legality of the rules. The Movants also contend that a stay pending appeal would be appropriate to avoid the chaos, extreme inefficiency and wasteful repetition of claim processing that would result from implementing the rules, having thousands of New Jersey healthcare practitioners change their procedures and submit claims under the new rules, and then, assuming they are successful, having these practitioners again change procedures and resubmit claims while also requiring insurers to reprocess all claims. They also assert that a failure to stay the rules will compromise the quality of and access to care by creating a risk that physicians will be unwilling to provide certain services to PIP patients due to the low fees provided for such services in the fee schedules. The Movants further contend that the amendments to the rules on attorney's fees in PIP arbitrations will encourage insurers to deny coverage and prolong arbitrations, which will result in attorneys declining to accept PIP cases for arbitration and compromise the effectiveness of the PIP dispute resolution program.

Finally, the Movants aver that a balancing of the equities favors a grant of the stay.

STANDARD OF REVIEW

It is well settled that Movants have the burden of establishing that a stay should be granted in this matter by clear and convincing evidence. American Employers' Insurance Co. v. Elf Atochem N.A., Inc., 280 N.J. Super. 601, 611, fn8 (App. Div. 1995); Subcarrier Communications, Inc. v. Day, 299 N.J. Super. 634, 639 (App. Div. 1999) (citing American Employers' Ins. Co., supra). In this application, Movants have failed to recite facts in the moving papers which meet the legal requirements entitling them to the relief requested.

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

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

LIKELIHOOD OF SUCCESS ON THE MERITS

First, Movants failed to establish that there is a reasonable probability that they will prevail on the merits of their appeal. It is “well-established” that administrative regulations enjoy a presumption of validity. N.J. State League of Municipalities v. Department of

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

A) Fee Schedules Meet the Statutory Standard

To demonstrate that they are likely to succeed on the merits of their appeal, the Movants assert that the new rules and amendments violate the statutory requirement that the Physicians' Fee Schedule incorporate the reasonable and prevailing fees of 75 percent of practitioners within the region. The Department disagrees because the fee schedules are consistent with this statutory requirement.

In support of its claim that the newly adopted Physicians' Fee Schedule does not meet the statutory standard, Movants cite a report by Sean M. Weiss, described by the Movants as a highly qualified expert in the fields of coding, regulatory compliance, Medicare reimbursement issues and fee schedule analysis. Mr. Weiss' report was submitted with the comment on the rule from the New Jersey Healthcare Coalition. The report concludes that the Department failed to comply with the statutory mandate because it did not use an accepted methodology to develop the Physicians' and ASC Fee Schedules.

Initially, it must be noted that the statutory mandate established by N.J.S.A. 39:6A-4.6(a) to set fees at the reasonable and prevailing fees of 75 percent of practitioners "within the region" has been historically difficult to achieve because there is no single existing database setting forth the reasonable and prevailing fees of 75 percent of all of the medical practitioners in the State, nor is there any "accepted methodology" to calculate those fees as asserted in Weiss' report. The reality is that, depending upon the payor and the nature of the health insurance policy or health benefits plan under which coverage is provided, physicians and ASCs are paid different amounts for the same service. Nevertheless, the Department in this adoption meets this statutory standard by utilizing the methodology for calculating the fee reimbursement amounts that was affirmed by the Appellate Division in the last PIP appellate challenge and by using updated data and a new proprietary source of paid fee data, namely FAIR Health. See In re Adoption of N.J.A.C. 11:3-29, 410 N.J. Super. 6 (App. Div. 2009).

The Weiss report states that the Department used a "blend" of different sources to establish the Physicians' Fee Schedule including Ingenix data and Medicare payment rates based on the 2007 Resource Based Relative Value Scale ("RBRVS"). The report also states that Ingenix is an extremely unreliable source for fee data, citing previous litigation initiated by the

New York Attorney General's Office. The report further stated that the Department failed to use a Medicare conversion factor to adjust 2007 Medicare data for use in 2012. The Movants' reassert all of these allegations in their stay motion before the Commissioner.

All of these assertions by the Movants, as first put forth in the Weiss report, are factually incorrect and demonstrate no likelihood that the Movants will prevail on the merits of the appeal. As discussed in the adoption, Mr. Weiss apparently misread a reference to In re Adoption of N.J.A.C. 11:3-29, supra, that appeared in the Notice of Proposal. That reference describes the Department's methodology for setting the Physicians' Fee Schedule in the prior promulgation and notes that the Department used the process of that methodology, which was upheld by Appellate Division in 2009, to calculate the Physicians' Fee Schedule in the adopted new rule. The Department did not use 2007 RBRVS or any Ingenix data to establish the fee schedule in the November 2012 adoption. As described at length in the Summary to the proposal, the Department used 2011 RBRVS and Medicare data in addition to other sources of paid fee information, such as FAIR Health and insurer data.

Movants also aver, citing again to Mr. Weiss' report, that the Department erred in failing to use the FAIR Health database, the successor to Ingenix, in setting the Physicians' Fee Schedule and that this resulted in the fees on the Physicians' Fee Schedule being set at far less than the reasonable and prevailing fees of 75 percent of the practitioners in the region. This is also incorrect, as discussed more fully below. Additionally, the Weiss report includes a comparison of the fees for a list of 76 CPT codes on the Physicians' Fee Schedule with the amounts from the FAIR Health Consumer Cost Lookup in an attempt to demonstrate that the Department did not use FAIR Health data and that the fees do not meet the statutory standard. Mr. Weiss is apparently unaware that the fees available on the FAIR Health Consumer Cost

Lookup are from a database of billed fees. The Department only uses paid fee databases in its compilation of the Physicians' Fee Schedule. Paid fees were first utilized in the fee schedule rules and amendments proposed December 18, 2000 at 32 N.J.R. 4332(a), were used again in the 2007 PIP rule amendments proposed September 5, 2006 at 38 N.J.R. 3437(a), and such use was affirmed by the Appellate Division twice in Coalition for Quality Health Care, et al. v. Department of Banking and Insurance, 358 N.J. Super. 123 (App. Div. 2003) and In re Adoption of N.J.A.C. 11:3-29, supra. Basing the fee schedule on paid fees was thus expressly litigated and found to be consistent with the applicable statutory standard. As such, Weiss' comparison of billed fees in his report to the fees on the Physicians' Fee Schedule provides no basis to demonstrate that the adopted fees fail to meet the statutory standard.

The Movants argue for the use of FAIR Health data to set the Physicians' Fee Schedule by stating that,

> FAIR Health is an unbiased, not for profit database which precisely comports with New Jersey's statutory mandate of calculating the New Jersey physicians' fee schedule. This database now serves as the benchmark for evaluating geographically specific physician fees by CPT code based on various percentiles. (Movants' Brief at 5).

As part of the development of the Physicians' Fee Schedule, the Department purchased the FAIR Health allowed (paid) fee database to provide another paid-fee data source against which to check its fee schedule and, as noted in the Summary of the Notice of Proposal of the rules, the fees on the Physicians' Fee Schedule were generally comparable or higher than those on the FAIR Health allowed fee database. Consequently, the Department utilized and relied upon the exact source of fee data touted by the Movants as "precisely comporting" with the mandate of N.J.S.A. 39:6A-4.6 and as "the benchmark" for setting fees by percentiles on a geographic basis and by CPT code. In light of this, the Movants' allegation that the Department used flawed and

unreliable data that fails to meet the statutory standard rings hollow and clearly fails to demonstrate the likelihood of success on appeal.

The Movants also assert that the Department failed to meet its obligation to adjust the fee schedule biannually for inflation as required by N.J.S.A. 39:6A-4.6(a). This allegation fails to demonstrate a likelihood of prevailing on appeal. As noted in the Proposal, the Department used the 2011 Medicare RBRVU to establish the new Physicians' Fee Schedule. The 2011 Medicare RBRVU formula is updated annually to reflect changes in the Medicare Economic Index, a weighted and average price index that measures practice cost inflation due to changes in physicians' services. For the existing fees on the schedule, this update resulted in an overall 7 percent increase in reimbursement amounts and the Department has no obligation to update the newly added CPT codes for inflation in this Adoption. See In re Adoption of N.J.A.C. 11:3-29, supra, 410 N.J. Super. at 46. Therefore, the Department's obligation to update the fee schedules for inflation has been met and this argument is unlikely to prevail on appeal.

The Movants also assert that the HOSF and ASC Fee Schedules do not meet the statutory mandate because they are set at 300 percent of the respective Medicare fee schedules for those services. The Movants state that Medicare is a government-subsidized program that bears no rational relationship to prevailing market fees. As noted above, the Department uses paid fee databases in establishing its fee schedules. The Department is not aware of any available paid fee database for either ASC or HOSF facility fees other than Medicare. Moreover, a multiplier of the Medicare fee schedule for these services is used by many other payors. In the 2007 amendments to the PIP rules, the Department similarly relied upon the Medicare fee schedule to set the first ASC facility fee schedule due to the dearth of data regarding reasonable and prevailing facility fees, and the Appellate Division determined that this approach was reasonable.

In re Adoption of N.J.A.C. 11:3-29, supra, 410 N.J. Super. at 44-45. The lack of data for facility fees still exists, and in 2007 Medicare established a new methodology for determining ASC facility fees. In light of these difficulties and developments, the Department believes that basing the new ASC and HOSF Facility Fee Schedules on the revamped Medicare methodology is reasonable and appropriate in light of the Appellate Division's prior decision.

The Medicare fee schedules for ASCs and HOSFs are established by using the relative value Ambulatory Payment Classification ("APC") groups and the relative payment weights for surgical procedures that have been developed under Medicare's Hospital Outpatient Prospective Payment System ("OPPS") to create payment groups and the relative payment weights for surgical procedures performed in ASCs and HOSFs. The Medicare OPPS payment rates are based on relative payment weights, which are updated annually based on the most recent year of hospital outpatient claims data and hospitals' latest Medicare cost reports. In addition, the APCs have been continually refined over the past six years through the work of the Advisory Panel on Ambulatory Payment Classification Groups ("APC Panel") and as a result of comments received during the OPPS annual rulemaking cycles. Moreover, the Centers for Medicare and Medicaid Services ("CMS") has stated that it believed that the APC groups had matured with respect to their clinical and resource homogeneity, and that the relativity in resource utilization among APCs containing surgical procedures had stabilized. These payment weights are adjusted to reflect local wage and practice costs to produce the fee schedules. The Department believes that, in the absence of any other paid fee database and the Appellate Division's decision in In re Adoption, this methodology meets the statutory standard.

In total, the Movants' assertions are factually incorrect and fail to demonstrate any likelihood of prevailing on the merits of the appeal with regard to adoption of the new fee schedules.

B) Restrictions on Procedures in ASCs

The Movants' second basis for asserting that the rules are unlawful or invalid as a matter of law is that the Commissioner exceeded his authority by providing in the fee schedules that certain procedures will not be reimbursed unless they are performed in hospitals or HOSFs. The Movants state that the Department does not have the legal authority to determine whether certain outpatient surgeries can be performed in ASCs and therefore the regulation that selects the venue for reimbursement is ultra vires.

The Department's rule does not determine where outpatient surgeries can be performed. It simply limits the reimbursement for such procedures in accordance with its statutory obligation in N.J.S.A. 39:6A-4 to 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." Pursuant to N.J.S.A. 39:6A-4.6a, the Commissioner also has the exclusive statutory authority to exercise his technical expertise to promulgate schedules of fees in a necessary regulation. As part of its obligation to only provide for the reimbursement of appropriate treatment, the Department determined it was necessary and appropriate to incorporate a standard for determining which procedures can be safely performed in an ASC. It has decided to utilize the standards established by one of the nation's largest payors, Medicare, for this determination. The assertion 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.

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 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. "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 Movants argue that this Medicare standard is outdated because it is based on a 5 year-old CMS guideline and because the Medicare population is different. The fact that the Medicare determination guideline was issued five years ago is of no import because it is still in use today and the CMS, which does yearly updates to the Medicare fee schedules, has found no justification to change this determination. The Movants assert that improvements in technology have eliminated these legitimate patient safety concerns, but point to no specific advancements. Furthermore, the assertion that the purported differences in the Medicare population makes this

standard inappropriate for application here are similarly unpersuasive because the standards are based on the clinical characteristics of the procedures and not based upon the age of the patient. Overall, 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 is reasonable and medically sound.

Furthermore, the Department also does not agree that the rules as adopted usurp the power of the Board of Medical Examiners or the Department of Health and Senior Services as alleged by the Movants. The Department's rules and fee schedules only apply to the reimbursement of medical benefits provided under the personal injury protection coverages in private passenger automobile insurance policies, which is well within the express statutory authority granted to the Commissioner in N.J.S.A. 39:6A-4 and -4.6. In light of the above, it is clear that 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, and the new ASC Facility Fee Schedule falls within this power. Coalition for Quality Health Care v. NJ Dep't of Banking and Ins., 348 N.J. Super. 272, 309 (App. Div. 2002). In sum, the Movants have failed to demonstrate a likelihood of success on the merits of this issue on appeal.

C) Amounts of ASC Reimbursements Compared to HOSFs

The Movants' third basis for asserting that the rules are unlawful or invalid as a matter of law is that the Department erred in providing that an ASC will be reimbursed at improperly low

facility fees compared to a HOSF for the same procedures. In support of this argument, the Movants reference a statement in the Summary to the Notice of Proposed Substantial Changes Upon Adoption that averred that, due to higher practice costs, HOSF fees are approximately 35 percent higher than ASC fees for the same services. See 44 N.J.R. 384. The Movants then analyze the percentage difference between the facility fees for each entity on the adopted fee schedules in an attempt to demonstrate that the ASC fees are arbitrarily low. However, the 35 percent figure in the Summary to the Notice of Proposed Substantial Changes Upon Adoption was an error. It mistakenly referred to the difference between the national Ambulatory Payment Classification amount for each service as set by CMS and the ASC Facility Fee Schedule amount, and did not include the local wage adjustment percentages which, as the commenter noted, increase the percent difference between the ASC and HOSF facility fees. As noted above, the ASC and HOSF fees are established by using the relative value Ambulatory Payment Classification (APC) groups and the relative payment weights for surgical procedures that have been developed under the hospital Outpatient Prospective Payment System (OPPS). By analyzing the fee differences based upon this mistaken 35 percent figure which did not include local wage adjustment percentages, the Movants' analysis of the fee differences is based upon a flawed estimate of differences in practice costs. The Department when calculating the facility fees by CPT code for ASCs and HOSFs included the local wage adjustment percentages, and these fees are set at the correct rates to reflect the differences in practice costs between the two types of facilities. Thus, contrary to the Movants' assertion, the difference in the levels of reimbursement is not arbitrary, but is based on the difference in cost between providing services in ASC's and HOSF's. For these reasons, the Movants have failed to demonstrate a reasonable likelihood that they will prevail on the merits of this issue.

D) Attorney's Fees in PIP Arbitrations

In further support that they are likely to prevail on the merits of their appeal challenging the rules, the Movants assert that the Department erred by adding a process to N.J.A.C. 11:3-5.6 by which dispute resolution professionals ("DRPs") shall award reasonable attorney's fees for successful claimants. Specifically, the Movants argue that the adopted new rules exceed the Department's statutory authority because they attempt to regulate the practice of law, which is the exclusive province of the New Jersey Supreme Court, and because the Department only included provisions for downward adjustments of attorney's fees and did so improperly. The Movants' arguments fail to demonstrate that they are likely to prevail on the merits of the appeal on this issue.

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

incorporated the courts' own jurisprudence into N.J.A.C. 11:3-5.6(e) which requires DRPs to analyze the reasonableness of attorney's fee awards. The adopted amendments require the DRP to complete and memorialize the courts' attorney fee analysis in the arbitration decision prior to making an award of attorney's fees. Thus, this rulemaking is well within the Department's purview to regulate the conduct of the PIP arbitrations.

As put forth during the rulemaking, the Department obtained data on the amounts awarded to claimants and paid to attorneys in 2010. It appeared from this data that in many instances DRPs failed to complete the statutorily required analysis to determine if the requested fee amounts are consonant with the amount of the award pursuant to N.J.S.A. 39:6A-5.2(g), and made no analysis of the requested attorney fee amount under the jurisprudence of this State. Of the 10,703 awards that included attorney's fees, in 3,460, or 31 percent of them, the attorney fee awarded was higher than the PIP benefits awarded. For example, one attorney received a fee of $3,380 for a case where only $375 was awarded in PIP benefits. The most common attorney fee awarded for all cases was $1,200. For cases where the PIP benefit awarded was $500 or less, the most common attorney fee was $1,000. For cases where the PIP benefit awarded was between $5,000 and $10,000, the most common attorney fee was $1,200. In light of the fact that the Supreme Court has not issued a schedule for attorney fee awards in PIP arbitrations, and that the DRPs often failed to analyze requests under N.J.S.A. 39:6A-5.2(g) and the jurisprudence of this State, the Department's incorporation of the courts' process to determine reasonable attorney's fees is not arbitrary, capricious or unreasonable.

As noted above, the Department incorporated the jurisprudence of this State which establishes how to determine the reasonableness of attorney fee awards under a fee-shifting statute such as N.J.S.A. 39:6A-5.2(g) that specifically provides that the fees should be consonant

with the amount of the arbitration award. See, Rendine v. Pantzer, 141 N.J. 292, 335-345 (1995); Szczepanski v. Newcomb Medical Center, Inc., 141 N.J. 346 (1995); Furst v. Einstein Moomjy, Inc., et al., 182 N.J. 1 (2004); Allstate Ins. Co. v. Sabato, 380 N.J. Super. 463, 472-474 (App. Div. 2005); and Scullion v. State Farm Ins. Co., 345 N.J. Super. 431 (App. Div. 2001). The Movants assert that the Department misconstrued this jurisprudence by failing to include upward adjustments of attorney's fees in cases where the attorney's compensation is not guaranteed. The Department disagrees that this argument demonstrates that the Movants are likely to prevail on the merits of the appeal.

The adopted rule incorporates the basic lodestar analysis in the caselaw that comports with the statutory authority in N.J.S.A. 39:6A-5.2(g) requiring the attorney's fee to be "consonant" with the amount of the PIP arbitration award. The Department believes that contingency fee enhancements in most instances would run counter to this statutory requirement, and therefore the adopted rule does not specifically provide for a contingency fee enhancement analysis as authorized in Rendine, supra, 141 N.J. at 337-341. Additionally, as noted by the Rendine court, any contingency enhancement should consider whether the "likelihood of success is unusually strong" and evaluate whether the risk that counsel would come away empty-handed is remote. Id. at 340-341. To what degree attorneys in PIP arbitrations operate on a contingency fee basis is not known to the Department; moreover, PIP arbitrations are not as procedurally complex or time consuming as traditional litigation, where attorneys who agree to a contingency fee agreement incur substantial expenditures of time, resources, and risk of non-payment. Nevertheless, nothing in the rule prohibits counsel from requesting such contingency fee enhancements in PIP arbitration awards and, if requested, DRPs would have to analyze whether

an upward adjustment of the lodestar is appropriate and "consistent with the jurisprudence of this State," as espoused in Rendine. See N.J.A.C. 11:3-5.6(e).

The Movants also argue that the Department's rule fails to recognize that "compatibility" is not the same as proportionality, and therefore the Movants are likely to prevail on appeal. In N.J.A.C. 11:3-5.6(e)2, the Department expressly requires the DRPs to analyze whether the attorney's fee is "consonant with the amount of the award" when the amount of the arbitration award is less than the attorney fee award pursuant to N.J.S.A. 39:6A-5.2(g). To do so, DRPs are directed to focus on whether the fees in those circumstances are compatible or consistent with the amount of the award in accordance with the definition of "consonant" previously noted by the Appellate Division in Coalition of Health Care Prof'ls, 323 N.J. Super. 207, 261-262 (App. Div. 1999). Additionally, N.J.A.C. 11:3-5.6(e)2 directs the DRPs to make a heightened review of the "lodestar" calculation where a request for attorney's fees is grossly disproportionate to the amount of the award as required by the jurisprudence of this State. Szczepanski, supra, 141 N.J. at 366-367; Scullion, supra, 345 N.J. Super. at 437-438. The Department does not confuse "compatibility" with "proportionality" in the rules because the rules provide for two separate analyses by the DRP, one to evaluate the consonance of the attorney's fee when compared to the award as required by N.J.S.A. 39:6A-5.2(g) and a second separate and heightened lodestar analysis if the attorney fee award is grossly disproportionate to the amount of the PIP award pursuant to the caselaw cited above. Furthermore, although fee-shifting statutes as a general proposition do not require proportionality between attorney's fees and the amount of the award, see Szczepanski, supra, 141 N.J. at 366, the statute at issue here does expressly require the attorney's fee to be consonant with the award amount. This is what the new rule does. Nothing in the rule requires proportionality as that analysis is utilized in contractual attorney fee cases.

See, Litton v. IMO Industries, 200 N.J. 372 (2009). For these reasons, the Movants have failed to demonstrate a substantial likelihood of success on the merits of the appeal with regard to adoption of N.J.A.C. 11:3-5.6.

E) Assignments of Benefits and Duties

The Movants assert that the Department erred by mandating in N.J.A.C. 11:3-4.9 that assignments of benefits to providers shall include both benefits and duties under the policy, and that this demonstrates a likelihood that they will prevail on appeal. The Movants misread the amendment to N.J.A.C. 11:3-4.9 which only provides that an "insured may only assign benefits and duties under the policy to a provider of service benefits." (Emphasis supplied). Nothing in the Department's adopted rule mandates the assignment of both duties and benefits; rather, the rule is permissive.

The Movants also assert that the amendment to N.J.A.C. 11:3-4.9 attempts to subvert the Appellate Division's decision in Selective Ins. Co. of America v. Hudson East Pain Management Osteopathic Medicine and Physical Therapy, 416 N.J. Super. 418 (2010), aff'd on other grounds 210 N.J. 597 (2012), by permitting the insurers to obtain extensive discovery in PIP arbitrations. The Movants fail to note that the Supreme Court did not adopt the reasoning of the Appellate Division in this matter, and fail to recognize that neither decision precluded the assignment of duties under the policy to a provider of service benefits. As noted by the Supreme Court on certification, the Appellate Division relied upon the legally significant distinction between an assignment, which conveys benefits or the potential to receive benefits, and a delegation, which conveys duties or obligations. Selective, supra, 416 N.J. Super. at 426 (citing 9 Corbin on Contracts §§ 47.1, 47.6 (John E. Murray, Jr. ed. 2007)). Based upon this distinction, the Appellate Division held that a general assignment of benefits in the PIP context and the specific

assignment at issue in the matter at bar did not function to impose the duty to cooperate under the policy unless the assignee providers expressly assent to assume the duty or were a party to the original agreement. Ibid.

In July 2012, the Supreme Court issued its decision in the case, 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, 210 N.J. at 606-607. The Supreme Court ultimately held that the duties of the assignee can be no greater than those of the assignor, and because the insured under the policy could not be compelled to provide the type of information sought by the insurer, then neither could the provider under the "duty to cooperate" clause. Id. at 607. Furthermore, the Court held that in PIP arbitrations, N.J.S.A. 39:6A-13(g) limits the exchange of discovery to information concerning a patient's "history, condition, treatment, dates and cost of such treatment" and the scope of this cannot be expanded. Id. at 608. The Department's rule does not seek to subvert or extend either decision.

The purpose of the amendment to N.J.A.C. 11:3-4.9 is to clarify the issue of whether duties under an auto insurance policy are assignable to providers generally and to permit an insurer to require that a provider accept the duty to cooperate if assigned by the insured. The rule in no way addresses the scope of discovery in a PIP arbitration as governed by N.J.S.A. 39:6A-13(g). In fact, the rule provides that insurers in permitting insureds to assign benefits may provide for the express assumption of duties under the policy, in addition to benefits, which was recognized as permissible by both the Appellate Division and the Supreme Court. N.J.S.A.

39:6A-4a authorizes the Commissioner to set forth the benefits provided under the policy and N.J.S.A. 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...” In the adoption, it was noted that certain providers have refused to respond to reasonable information requests by insurers in connection with the investigations of claims and that this clarification regarding the permissible assignment of both benefits and duties will enable insurers to require the provision of information during those investigations as long as statutorily permissible. 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 and intends to monitor its implementation. In light of the above, the Movants have failed to demonstration a likelihood of prevailing on the merits of this issue on appeal.

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

PUBLIC INTEREST

The public interest does not favor a stay of these rules pending appeal. PIP patients will continue to receive the same standard of care and providers will provide the same standard of care under the new rules and fee schedules. Permitting the new and amended rules to become effective on January 4, 2013, will benefit the interests of New Jersey auto insurance consumers, PIP patients and providers.

In enacting N.J.S.A. 39:6A-4.6(a), the Legislature required the Commissioner to develop fee schedules that reflect the prevailing fees for services in connection with PIP coverage. In Coalition for Quality Health Care, 358 N.J. Super. 123 (App. Div. 2003), the Appellate Division directed the Department to consider promulgating a more comprehensive Physicians' Fee Schedule than that in the former rules. The court did so because the inclusion of more CPT codes in the PIP fee schedules will enable insurers and providers to streamline their respective claims payment and submission systems, thereby reducing the administrative component of their total costs and fostering a reduction in the cost of PIP coverage. For this reason, and because these rules implement the public policy of this State expressed by the Legislature and interpreted by the courts as set forth above, the adoption of the new and amended rules is plainly in the public interest.

As noted in the Proposal, the new Physicians' Fee Schedule also increases the fees received for the CPT codes currently on the fee schedule by approximately 7 percent. These increases will enable providers to obtain higher reimbursements for medical procedures, dental treatments, ambulance services and durable medical equipment, all of which were delayed by the stay of the 2007 adoption. Moreover, the rules will benefit auto consumers and providers by setting new fee schedule amounts for more than 1,100 new CPT codes using the updated Medicare RBRVS schedule and at fee amounts based upon paid fees from FAIR Health at the 75th percentile, the NY Worker's Compensation Fee Schedule, and data on the amounts paid by auto insurers. This will provide cost certainty and billing simplification for an expanded number of medical treatments, decrease the need for arbitrations arising from disputes as to procedures' usual, customary and reasonable fee, and further the cost containment goals of Automobile Insurance Cost Reduction Act ("AICRA") by exerting downward pressure on rising PIP

premiums. Additionally, the new rules and schedules will ensure that only medical procedures that can be safely performed in ASCs will be reimbursable under PIP coverages, and expand the cost certainty encouraged by AICRA to HOSFs providing outpatient surgical procedures.

For all of these reasons, the public interest favors permitting the new and amended PIP rules and fees schedules to take effect. Finally, I also note that the Movants' submission made no mention of this prong of the four-part test for the ordering of temporary restraints. Consequently, it cannot be concluded that they have carried their burden of establishing that the public interest favors a stay.

BENEFITS VS. HARM OF GRANTING THE APPLICATION

On balance, the benefit of granting the stay will not outweigh the harm such relief will cause other interested parties. The Movants have provided no facts on which it may be concluded that the balance of the equities favors them. In contrast, the benefits to the vast majority of providers and New Jersey auto insurance policyholders of proceeding to implement these new and amended rules must be considered when balancing the equities in deciding the instant application. The rules effectuate substantial increases in the fees for most of the codes listed in the current Physicians' Fee Schedule. Further delaying the date on which these changes will become operative will adversely affect providers who perform the procedures and render the services to which these codes correspond.

In addition, the challenged adoption is the culmination of the Department's most recent efforts to fulfill the statutory mandate to establish a comprehensive fee schedule and update that fee schedules for inflation every two years. The rules implement the beneficial public policies that the application of current and comprehensive PIP fee schedules were intended to serve, including the dampening effect such schedules have on the administrative costs of providing PIP

coverage and medical care to auto accident victims. The adopted amendments also add a significant number of codes to the fee schedules. The adoption of this more comprehensive Physicians' Fee Schedule and of the amendments that address the fees that may be charged by ASCs will reduce the upward pressure on rates currently caused by the frequency of disputes and expensive arbitrations.

An objective evaluation of the foregoing compels me to conclude that the benefits of the rules going into effect on January 4, 2013, outweigh the conjectural inefficiencies and unsubstantiated claims of economic loss the Movants claim may result if their application is denied. Thus, the balance of equities does not support granting the requested relief.

IRREPARABLE HARM

Irreparable harm will not result to the Movants or their patients if the stay is denied. The Movants argue that if the rules go into effect providers will be required to create new claims submission systems, which will result in chaos, extreme inefficiency and wasteful repetition of claim processing. These assertions are at best speculative, as the Movants have provided no factual basis to support them. In reality, providers will merely need to change the amounts of their currently billed fees to the maximum amounts established in the amended schedules for services rendered on or after January 4, 2013. In addition, the process of providers generating and submitting bills to insurers for reimbursement takes time. The lag between rendering the service and billing for that service will allow providers adequate time to adjust to the new fee amounts. Moreover, if bills are submitted by providers at rates other than the amounts specified in the schedules, the impact of such over or underbilling will be null because insurers themselves will adjust payment amounts to comply with the fee levels prescribed in the schedules. Finally, it is inevitable that both providers and insurers will be processing bills under both fee structures

until the bills for all services rendered prior to the operative date of the rules have been submitted and paid. Such a period of operating under dual claims systems will be required regardless of the amounts included in the amended fee schedules.

Notably, much of the projected harm cited by the Movants is essentially monetary in nature. The courts have consistently held that the loss of income or pecuniary harm does not constitute irreparable harm for purposes of obtaining an interlocutory injunction. Bd. of Ed. of Union Beach v. N.J. Ed. Ass'n, et al, 96 N.J. Super. 371, 391 (Ch. Div. 1967), aff'd 53 N.J. 29 (1968). The most pervasive harm cited in support of the motion is that providers would be required to modify their claim submission systems a second time if, after having initially done so in response to the adoption, the Movants succeed in their challenge to the rules, resulting in a reversion to the fee schedules that existed prior to the January 4, 2013 operative date of the new and amended rules. While complying with such a reversion to the former rules might be frustrating and inefficient, the Movants' position inherently recognizes the ability of providers to realign and readjust their systems to restore the status quo ante. Thus, this argument alone demonstrates that the prospective harm on which Movants place the greatest emphasis in their stay request is not "irreparable."

The Movants also assert that a failure to stay the rules will create a strong risk of a shortage of physicians willing to treat PIP patients, which will compromise the quality of and access to care. They then contend that this will result in irreparable harm to auto accident victims, since the denial of needed care cannot be remedied by money damages, and such damages cannot be obtained from the Department. Like their argument with respect to the "chaos" and inefficiencies that would result from duplicative system modifications by providers, these arguments are also purely speculative. The Movants have supplied no facts in support of

their conclusions, and have merely listed a speculative parade of horribles that will result from the rules becoming operative. Indeed, during each adoption of PIP rule amendments, one or more parties have made this argument; however, each PIP adoption and the new fee schedules associated therewith have eventually become operative with little to no revision after appellate review, and yet, no treatment crisis has ever occurred.

By primarily basing the levels of fees in the revised Physicians' Fee Schedule upon: paid fee data supplied by FAIR Health at the 75th percentile, the reliability of which is highly extolled by the Movants in their application; upon data reflecting claim payments actually made by auto insurers; and, by utilizing the methodology affirmed by the Appellate Division in In re Adoption, supra, the Department has ensured that the payment levels in the new schedule are not inappropriately low, but instead meet the statutory standard of approximating the reasonable and prevailing fees at 75th percentile on a regional basis.

Finally, it is incumbent upon me to note that truly irreparable harm could result from a stay of these rules. These rules provide necessary, but reasonable, reimbursement increases for all PIP providers of medical and dental treatments, transportation, therapy, and DMEs, which were delayed by the litigation of the 2007 PIP amendments and the lengthy stay of implementation of those rules for almost two years. They also strike an appropriate balance by including more than 1,100 new CPT codes in the schedule to ensure cost certainty, fewer arbitrations over UCR, a reduction in fraudulent activity, and the containment of PIP premium costs for all New Jersey auto insureds. A lengthy delay of the implementation of these rules will be costly across the board, and in particular to New Jersey policyholders and providers who are not affiliated with the Movants. This is an added consideration as to why this stay request must be denied.

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

CONCLUSION

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

IT IS SO ORDERED this 23rd day of November, 2012.

Kenneth E. Kobylowski
Acting Commissioner