

INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF PROPERTY AND CASUALTY

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

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

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

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

Authorized By: Steven M. Goldman, Commissioner, Department of Banking and Insurance.

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

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2006-293

Submit comments by November 4, 2006 to:

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The agency proposal follows:

Summary

N.J.S.A. 39:6A-4.6(a) requires the Commissioner of the Department of Banking and Insurance (Department) to promulgate and biennially review medical fee schedules for the reimbursement of health care providers providing services or equipment for which reimbursement is made under the medical expense benefit of the Personal Injury Protection (PIP) coverage and medical expense benefits by motor bus insurers. The statute requires

that the fee schedules “incorporate the reasonable and prevailing fees of 75 percent of the practitioners” within a region. The medical fee schedules establish per service limits of liability for reimbursement of medically necessary services provided as part of the PIP coverage.

In accordance with N.J.S.A. 39:6A-4.6(a) and the Appellate Division case, *In the Matter of the Commissioner’s Failure to Adopt 861 CPT Codes and to Promulgate Hospital and Dental Fee Schedules*, 358 N.J. Super 135 (App. Div. 2003), the Department is proposing amendments to N.J.A.C. 11:3-29, to repeal and propose new Appendix, Exhibits 1, 4, 5 and 6, the physicians’, durable medical equipment, ambulance fee schedules and the fees subject to the daily maximum, respectively. In addition, the Department is proposing a new fee schedule for Ambulatory Surgical Centers (Appendix, Exhibit 7).

As discussed in the amendments to the fee schedule rules and amendments proposed December 18, 2000 at 32 N.J.R. 4332(a) and affirmed in *Coalition for Quality Health Care, et al v. Department of Banking and Insurance*, 358 N.J. Super 123, (App. Div. 2003), the Department bases its fee schedules on paid rather than billed fees. In developing the physicians’ fee schedule, the Department contracted once again with Ingenix, the largest purveyor of fee schedules for information from its paid or “allowed” fee databases. Ingenix provided information on paid fees in preferred provider organizations (PPOs) at the 80th percentile. For comparison to other payors, the Department has looked at the Part B participating provider fee schedule of Medicare (Medicare fee schedule), the largest medical payor in the United States, the New York State Worker’s Compensation and No Fault Fee Schedule (NY fee schedule) and the use by other states and the District of Columbia of fee schedules based on a multiple of the Medicare fee schedule.

The Department determined that since, as noted below, the Medicare fee schedule is extremely comprehensive and is resource based, it was appropriate to calculate its Physicians' Fee Schedule as percentages of the current Medicare fee schedule. In developing these proposed amendments, the Department informally sought public input pursuant to N.J.A.C. 17:30-5.3(a), by which it solicited input from medical service providers, insurers and other interested parties. Initially, the Department had considered using a multiplier of 120 percent of the Medicare fee schedule since it corresponded well to much of the paid fee data collected by the Department. Based on comments from providers concerning the additional administrative costs of treating PIP patients, the Department raised the percentage to 130 percent of the Medicare fee schedule in the current proposal. However, the Department recognized that, for certain CPT codes, fees set at 130 percent of the Medicare fee schedule would not reflect the "reasonable and prevailing" fees and would thus produce an anomaly. Through the informal preproposal process the Department also solicited comments from providers and payors to identify such anomalies. For example, the Department recognized that where a CPT code on the current fee schedule is greater than 130 percent of Medicare, the new fee was calculated as the percentage of the Medicare fee schedule that most closely approximated the current fee. Based upon the information submitted by providers through the informal preproposal process and paid fee data provided by insurers, a number of fees have been set at higher or lower percentages of Medicare.

A percentage of the Medicare fee schedule is an appropriate base for calculating the New Jersey automobile medical fee schedule. The Centers for Medicare and Medicaid Services (CMS) with input from the provider community, calculate a relative value unit (RVU) for the physician work, practice expenses and malpractice premium expense for each

Current Procedural Terminology (CPT) code. These RVUs are then adjusted by a geographic practice cost index (GPCI) that reflects the impact of the costs of physician work, practice expenses and malpractice cost in a specific geographic region. The result is multiplied by a dollar amount known as the Medicare conversion factor to produce the fees for each Medicare region.

In setting the current fees as a percentage of Medicare, the Department is not taking the position that future updates to the schedule, such as the biennial review required by N.J.S.A. 39:6A-4.6(a), will use the same percentages of Medicare. The Department recognizes that future updates to the conversion factor developed by CMS, the amount by which the GPCI adjusted RVUs are multiplied to produce the actual Medicare fees, is required by Federal law to include factors that are not related to the cost of providing care to Medicare beneficiaries. Therefore, the Department will evaluate future adjustments at the time of the review.

As noted above, prior to making this formal proposal the Department obtained input from interested parties, both providers and payors, pursuant to N.J.A.C. 1:30-5.3(a). Many comments and suggestions were received that were integrated into the proposal and the Department appreciates the time and effort that provider groups, in particular, expended in giving us information. However, virtually all providers stated that it costs more to provide services to PIP patients because automobile insurers unreasonably delay reimbursement. Because prompt and proper payment by insurers is necessary to the full success of a fee schedule, the Department reminds insurers of their obligations in this regard. The Department is concerned by provider reports and other information indicative of insurer attempts to deny or delay payments, or to make reduced payments where full payments are

required. It is the Department's position that pre-certification should guarantee prompt and full payment except in extraordinary circumstances such as where there is no coverage or evidence of fraud exists. The Department is currently examining information about insurer attempts to improperly deny, delay or reduce payments, and is prepared to act in accordance with its findings.

N.J.A.C. 11:3-29.1(c) is being amended to clarify that the exemption is from the subchapter, not just the fee schedules. A new paragraph (c)4 is being added to include inpatient services provided in hospitals and other institutions to the list of entities and services that are not subject to this subchapter. An exemption from the fee schedules for inpatient services is currently included in the current rule at N.J.A.C. 11:3-29.4(a). That language has been moved to new N.J.A.C. 11:3-29.1(c)4.

The Department is proposing to amend N.J.A.C. 11:3-29.2 to include several new definitions including "ambulatory surgery facility," "ambulatory surgical case" "co-surgery," "modifier" and "multiple surgeries" and "powered traction device." The definition of "CPT" has been amended to update the version used in this proposal and to include the copyright information from the American Medical Association. The definition of "HCPCS" has been amended to refer to the new name of the Federal agency that governs Medicare.

N.J.A.C. 11:3-29.3 is being amended to change the definitions of the geographic regions used for the fee schedule. The Department has determined to use the same two geographic regions used by Medicare, North and South, instead of the three regions used in the current version of the fee schedule. The regions are defined by county and zip code.

N.J.A.C. 11:3-29.4(a) is proposed to be amended to delete "provider's" from the reference to usual, reasonable and customary fees in accordance with the revised definition

of this term at N.J.A.C. 11:3-29.4(e) and to delete the exemption for inpatient hospital services that has been recodified at N.J.A.C. 11:3-29.1(c). The exemption from the physicians' fee schedule for services provided in the trauma units of Level I and Level II trauma hospitals has been revised to more clearly express the Department's intent in providing the exemption. The rule has also been amended to provide a higher reimbursement for surgical services performed in hospital emergency rooms.

N.J.A.C. 11:3-29.4(c)1 is being amended to clarify that for items of durable medical equipment for which a rental fee is provided, the insurer's limit of liability is 15 times the rental fee "or the purchase price of the item, whichever is less".

The Department is amending N.J.A.C. 11:3-29.4(e)1 to provide some parameters for the determination of the usual, customary and reasonable fee for CPT codes that are not on the fee schedule. The proposed amendments state that the provider should bill the insurer with his or her usual and customary fee, that is, the fee that he or she receives for the service from other private payors including health insurers, managed care organizations and workers' compensation managed care organizations. The insurer determines if the fee is reasonable by comparing it to fees paid for that service in that region or zip code. This two-step procedure is consistent with the finding in the *Tito Cobo v. Market Transition Facility* (293 N.J. Super 374, App. Div. 1996) case. Cobo states, "The effectiveness of the medical fee schedules in reducing the cost of auto insurance in New Jersey is dependent upon adherence by insurers to this review process." The Department is also including in the definition the provision that insurers may use regional or zip code information contained in national fee databases such as those maintained by Ingenix or Wasserman to determine the reasonableness of fees. In correspondence and meetings with the Department, providers

have routinely used the Ingenix databases as evidence of appropriate fee levels, it is entirely appropriate for insurers to use such databases in determining the reasonableness of fees.

N.J.A.C. 11:3-29.4(e)2 is proposed to be amended to require that the applicable provisions of N.J.A.C. 11:3-29.4 concerning billing and payment are applied to out-of-State fees and fees that are not on the schedule. Examples of such provisions would be the use of modifiers, multiple surgical procedures and restrictions on unbundling.

N.J.A.C. 11:3-29.4(f)1 through 6 are proposed to be amended to conform the language concerning fees for multiple and bilateral surgeries, co-surgeries and the use of assistant surgeons to the language in the Medicare Claims Processing Manual. The amendments clarify that the reductions only apply to surgical procedures, give the modifiers for use in reporting such surgical procedures and revise the formula to 100 percent of the eligible charge for the highest cost procedure and 50 percent of the eligible charge for all subsequent procedures. The general language in existing N.J.A.C. 11:3-29.4(f)4 concerning the payment of multiple procedures and services has been deleted and replaced with more specific requirements for the reimbursement of assistant surgeons and non-physician surgeons. N.J.A.C. 11:3-29.4(f)6 has been added to address how to determine when the services of co-surgeons and assistants surgeons are reimbursable. N.J.A.C. 11:3-29.4(f)7 has been added to address the situation where co-surgeons and assistant surgeons do not use the required modifier and the insurer pays 100 percent of the eligible charge to one surgeon.

N.J.A.C. 11:3-29.4(g), which prohibits unbundling of codes or fragmented billing, is being amended to adopt and incorporate by reference the National Correct Coding Initiative Edits, created and updated by CMS. These edits indicate which CPT codes cannot be billed

with other codes because the services described in the other code are already included in the first code. Most providers should already be familiar with this system since it is used by Medicare. In addition, the proposed amendments include several specific examples of prohibited unbundling. The prohibition on the separate reimbursement for hot and cold packs is recodified as N.J.A.C. 11:3-29.4(g)1. Proposed N.J.A.C. 11:3-29.4(g)2 prohibits billing a separate code for reading an X-ray or MRI report as part of an office visit where the technical and professional component of that service has already been reimbursed. It also clarifies that the code for interpretation of an imaging study can only be used when done by a provider in separate facility or practice. Proposed N.J.A.C. 11:3-29.4(g)3 clarifies that fluoroscopic guidance in certain surgical procedures can only be billed per spinal region, not by level. Proposed N.J.A.C. 11:3-29.4(g)4 references material on the appropriate use of Electrodiagnostic nerve testing found in Appendix J of the CPT manual as a reference for proper reimbursement of these procedures. Proposed N.J.A.C. 11:3-29.4(g)5 states, following Medicare, that moderate or conscious sedation administered by the provider who is performing the procedure is not separately reimbursable. Proposed N.J.A.C. 11:3-29.4(g)6 gives the circumstances where moderate or conscious sedation is reimbursable when administered by a second physician.

New N.J.A.C. 11:3-29.4(h) is being proposed to require that the codes for a nerve conduction study are only reimbursable when the results are interpreted by a physician who is on site and directly supervises the test.

Proposed new N.J.A.C. 11:3-29.4(i) would require that the results for nerve conduction studies and needle electromyography should be integrated into a unified diagnostic impression and are not reimbursable separately.

N.J.A.C. 11:3-29.4(h) is being recodified as subsection (j) with no change in text.

N.J.A.C. 11:3-29.4(i), recodified as subsection (k) is being amended to clarify the information that is required for reimbursement off codes for “unlisted procedures or services” that are not on the fee schedule.

Current N.J.A.C. 11:3-29.4(j) and (k) are being deleted since those requirements are now included in N.J.A.C. 11:3-29.4(f). N.J.A.C. 11:3-29.4(l) is being amended to clarify the requirements concerning CPT codes that can be billed as global fees or split into technical and physician components.

N.J.A.C. 11:3-29.4(m) is being amended to increase the amount of the daily maximum from \$90.00 to \$99.00 based on comments received from chiropractors that they are providing additional services. However, the Department is reviewing how chiropractic and physical therapy billing is handled in other states and plans to consider future rulemaking on this issue. N.J.A.C. 11:3-29.4(m) is also being amended to clarify the circumstances under which an insurer shall reimburse providers in excess of the daily maximum when the requirements of the paragraph are met. Several providers were concerned that the existing language that an insurer “is not prohibited” from reimbursing in excess of the daily maximum has been interpreted to mean that the insurer could simply decide not to reimburse in excess of the daily maximum regardless of the nature of the injuries of the patient and the treatment required. It was the Department’s intent for payors to provide reimbursement above the daily maximum if the provider can demonstrate that the severity or extent of the injury meets the requirements of the rule. The Department is also amending the rule to clarify that the daily maximum applies to any provider who performs the listed services, including dentists.

N.J.A.C. 11:3-29.4(n) is being recodified as of N.J.A.C. 11:3-29.4(m)1 since it refers to the Physical Medicine and Rehabilitation codes. The Department is adding N.J.A.C. 11:3-29.4(m)2 stating that powered traction devices are to be billed with the CPT code 97012 consistent with the Federal Food and Drug Administration's (FDA) designation of them as providing the modality of traction. N.J.A.C. 11:3-29.4(m)3 has been added stating that cold or low-powered laser treatment is included in the modality of infrared treatment represented by CPT code 97026 consistent with the FDA's designation of such modalities.

N.J.A.C. 11:3-29.4(m)4 is being added to incorporate the recent amendment to N.J.S.A. 39:6A-4, which states that physical therapy shall not be reimbursable under PIP unless rendered by a licensed physical therapist pursuant to a referral from a licensed physician, dentist, podiatrist or chiropractor within the scope of their respective practices. This clarifies that while patients can have direct access to physical therapy treatment in health insurance, referrals continue to be required for auto insurance medical expense coverage. The statute also states that physical therapy can only be provided by licensed physical therapists. The Department recognizes that other licensees routinely use the same CPT codes as those used by physical therapists but such treatment cannot be considered as or referred to as physical therapy.

Current N.J.A.C. 11:3-29.4(o) is being recodified as subsection (n). A new subsection (o), which sets the requirements for billing facility fees for Ambulatory Surgical Facilities or centers (ASCs) is being proposed. Certain types of same-day surgical or testing procedures can be performed in an ASC as a lower-cost alternative to a hospital. The physician services in ASCs are reimbursed according to the physicians' fee schedule. The ASC also charges a facility fee for the cost of the services provided by the ASC itself. Until now, these

facility fees have been unregulated and the Department has become aware that in some cases, facility fees have far exceeded what would have been charged by a hospital for the same procedure. Medicare has recently set facility fees for ASC's at a prospectively determined rate that approximates the costs incurred by ASCs in providing services. The rates are determined by conducting a survey of the audited costs of a sample of ASCs every five years. The rates are adjusted for inflation during the years when the survey is not conducted. The Department is using the Medicare system whereby procedures designated by CPT codes that are performed in ASCs are put into nine fee groups. Proposed new N.J.A.C. 11:3-29.4(p) clarifies what services and equipment are included or excluded from the facility fee. Proposed new N.J.A.C. 11:3-29.4(q) sets forth the multiple procedure reduction formula that applies to ASCs.

N.J.A.C. 11:3-29 Appendix, Exhibit 1 is proposed for repeal and a new Exhibit 1, Physicians Fee Schedule, is proposed to replace it. The existing fee schedule contains 92 of the most commonly used CPT codes in the treatment of auto accident injuries. The proposed new physicians' fee schedule contains more than a thousand additional codes. The additional codes on the schedule should lessen the number of disputes about fees, resolution of which has increased costs to both physicians and insurers. Exhibit 1 now contains a fee for anesthesia units. The Department has received a recent survey of paid fees for anesthesia units in New Jersey and has decided to use the 75th percentile of the median payer. In addition, the Department has added CPT 99140 that permits additional anesthesia units for anesthesia complicated by emergency conditions. Following Medicare, the fee schedule will no longer provide reimbursement for CPT 97014 – unattended electrical stimulation. Instead, this treatment will be reimbursed under HCPCS code G0283.

As noted above, the physicians' fee schedule includes the CPT code number, a column for the modifier, if any and a short description of the procedure. The next two columns of the schedule are the fees for the north and south regions and the last column is the ASC group, if any. The new fee schedule for ambulance services at N.J.A.C. 11:3-29 Appendix, Exhibit 4 includes several new codes and is based on 2005 Medicare rates for New Jersey. These fees are set at 100 percent of the current Medicare rates, consistent with the present rule.

The fee schedule for durable medical equipment and prosthetic devices is proposed as N.J.A.C. 11:3-29 Appendix, Exhibit 5. A modifier following the Federal Health Care Financing Administration's Common Procedure Code System (HCPCS) code is used to distinguish between equipment purchased new (modifier -NU), purchased used (modifier -UE), and rental equipment (modifier -RR). See N.J.A.C. 11:3-29.4(c). Modifiers are listed for applicable codes only. These fees are set at 100 percent of the current Medicare rates, consistent with the present rule.

Proposed new N.J.A.C. 11:3-29 Appendix, Exhibit 6, CPT Codes Subject to Daily Maximum, includes several changes. First, three new CPT codes have been added to the list of codes subject to the daily maximum: 97112 Neuromuscular Reeducation; 97530 Therapeutic Activities and 98943 – Chiropractic Manipulation –Extraspinal, 1 or more regions. N.J.S.A. 39:6A-4.6(b) permits the fee schedule to include a single fee for a group of services commonly provided together. The codes originally subject to the daily maximum included services commonly provided together at the time the fee schedule was amended. The Department has stated, however, that it was prepared to add codes to the daily maximum if the use of additional codes became so frequent as to qualify them as commonly

provided together. The Department has received information from various insurers that the use of the three codes mentioned above has increased dramatically. One insurer reported a 62 percent increase in the units billed of CPT 97112, a 33 percent increase in 97530 and a 130 percent increase in 98943. As these codes are now by their increased usage commonly performed together with the codes on the original list, the Department is adding them to the codes subject to the daily maximum. In addition, the Department is substituting the HPCPS code G0283 for CPT 97014 on the list of codes subject to the daily maximum. As noted above, Medicare has determined that G0283 is the appropriate code for reimbursement of unattended electrical stimulation.

In addition to adding codes to Appendix, Exhibit 6, the Department has added the description of the procedures such as 'Supervised Modality' or 'One-on-one patient contact required' from the CPT manual. The Department has also included notes with certain codes that clarify that the modality represented by the code includes modalities that providers may seek to bill separately with brand-name equipment.

The Department is proposing to delete the exemption from the daily maximum for osteopathic manipulation performed by an osteopath or medical doctor in Appendix, Exhibit 6. The exemption was included as a result of comments to an earlier proposal to the effect that osteopathic manipulation was sometimes performed by Doctors of Osteopathic (ODs) and Doctors of Medicine (MDs). The Department believes that the occasional use of the osteopathic manipulation codes should not reach the daily maximum and that multiple billings of codes should be subject to the same daily maximum as chiropractic manipulation when performed with other treatment modalities.

Proposed new N.J.A.C. 11:3-29 Appendix, Exhibit 7 contains the ASC facility fee for the nine groupings of CPT codes performed in ASCs. The Department is using a multiplier of the Medicare fee schedule for ASCs as is done in many other states. Ingenix has not established a database of ASC facility fees. The Department is setting the amount of the facility fees at 300 percent of the 2006 Medicare base rate and wage index for locality 14 for the South Jersey region and locality 15 for the North Jersey region. The Department believes that this percentage of Medicare for the ASC facility fees is appropriate based on information received during the informal preproposal process.

This rule proposal provides for a comment period of 60 days and, therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

The proposed repeals, new rules and amendments to the Medical Fee Schedules affect automobile insurers, purchasers of automobile insurance and health care providers who provide medical services and equipment to New Jersey resident insureds injured in accidents involving automobiles and/or buses.

The fee schedules have been revised and updated to include many more codes, thus enabling insurers and providers to streamline billing and claims paying systems. Dollar amounts appearing in the fee schedules “incorporate the reasonable and prevailing fees of 75 percent of the practitioners within the region” as required by N.J.S.A. 39:6A-4.6a.

Of major significance is the establishment of a fee schedule for ASCs. Pursuant to the proposed new schedule, the facility fees for procedures performed in ASCs will be one of nine fee groups. The Department believes that this approach will be supported by providers

and insurers since it will simplify the billing for these services, reduce the incidence of billing abuse and fraud, decrease the time required to pay claims and result in more effective cost containment.

Another change expected to favorably impact insurers and providers is the adoption of the National Correct Coding System edits that should prevent disputes about unbundling of services. Minimizing such disputes will facilitate the efficient processing of claims, alleviating administrative burdens on providers and insurers alike.

Economic Impact

The medical fee schedules and rules are intended to establish limits on the amount of medical expenses paid by insurers on behalf of New Jersey residents who are injured in automobile or bus accidents, thereby lowering the cost of automobile personal injury protection coverage and motor bus medical expense coverage in New Jersey.

Because many new codes are being added to the physicians' fee schedule, the reimbursement amounts heretofore paid for some generally categorized procedures may be reduced. Other fees, such as the daily maximum for physical medicine and rehabilitation codes have been increased.

Health care providers and insurers will incur some cost, initially, as a result of incorporating the revised fee schedules and rules into their respective billing and claims payment systems and procedures. The Department does not believe that these costs will be substantial. The overall effect of these proposed amendments, new rules and repeals is, however, expected to be a reduction in costs currently borne by insurers and, in turn, by insureds.

Additionally, the Department believes that the proposed repeals, new rules and amendments will have a favorable economic impact on insurers and providers by eliminating many costly disputes and ensuring that fees are uniform and not excessive. These rules and amendments should also reduce inefficiency in billing and payment fraud and enhance competition, all of which should exert downward pressure on private passenger auto insurance rates. As amended, these rules should also continue to provide a reasonable and prevailing level of reimbursement to providers.

Federal Standards Statement

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

Jobs Impact

The Department does not anticipate the creation of any jobs as a result of the proposed repeals, new rules and amendments. The Department invites commenters to submit any data or studies regarding the jobs impact of this proposal together with any written comments on other aspects of this proposal.

Agriculture Industry Impact

The proposed repeals, new rules and amendments will not have any impact on the agriculture industry in New Jersey.

Regulatory Flexibility Analysis

The Department's proposed repeals, new rules and amendments will apply to "small businesses" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. These "small businesses" are insurance companies authorized to write private passenger automobile insurance and/or motor bus medical expense coverage.

The revised rules will require that all automobile and motor bus insurers, including those qualifying as small businesses, implement the proposed fee schedule changes. Since medical fee schedules for automobile and motor bus insurers have been utilized for many years, the Department does not believe that compliance with the proposed new rules and amendments will require any additional professional services other than those used by insurers as part of their regular claim review processes. Insurers may incur a one time cost to distribute the new fee schedules, make necessary system adjustments, and for the training of personnel in the new rules. Accordingly, the Department does not believe that the requirements set forth in the proposed new rules and amendments impose any undue burden on insurers.

The proposed new rules and amendments provide no different reporting, recordkeeping or other compliance requirements based on business size. The requirement that the maximum reimbursement for treatment of injuries sustained in automobile accidents be established by the fee schedule is set by statute, N.J.S.A. 36:6A-4.6, which does not provide for any exceptional treatment based upon insurer size. To ensure that New Jersey resident insureds receive adequate treatment of injuries covered by PIP provisions, it is important that all automobile accident claims be administered in a similar manner. Thus, the

utilization of different compliance requirements would not be desirable or feasible. Therefore, for the reasons discussed above, and to continue to ensure consistency in the benefits provided to New Jersey insureds under their PIP automobile insurance coverage, no differentiation in compliance requirements is provided based on business size.

Smart Growth Impact

The proposed repeals, new rules and amendments will not have an impact on the achievement of smart growth or the implementation of the State Development and Redevelopment Plan.

Full text of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 11:3-19 Appendix, Exhibits 1,4, 5 and 6.

Full text of the proposed amendments and new rules follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

11:3-29.1 Purpose and scope

(a) – (b) (No change.)

(c) [These fee schedules do] **This subchapter does** not apply to the following:

1. (No change.)

2. Any other kind of insurance including health insurance, even when the health insurer may be required pursuant to its health insurance contract to pay benefits to, or on behalf of, a person who sustained bodily injury as a result of an accident while occupying, entering into, alighting from or using an automobile or motor bus, or as a pedestrian, caused by an automobile or motor bus or an object propelled by or from an automobile or motor bus;

[and]

3. Medical services or equipment provided outside of the geographic boundaries of New Jersey except as set forth in N.J.A.C. 11:3-29.4(d)2[.]; **and**

4. Inpatient services provided by acute care hospitals, trauma centers, rehabilitation facilities, other specialized hospitals, residential alcohol treatment facilities and nursing homes.

11:3-29.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Ambulatory surgery facility" or "ASC" means:

1. A surgical facility, licensed as an ambulatory surgery facility in New Jersey in accordance with N.J.A.C. 8:43A-1 in which ambulatory surgical cases are performed and which is separate and apart from any other facility license. (The ambulatory surgery facility may be physically connected to another licensed facility, such as a hospital, but is corporately, financially and administratively distinct, for example, it uses a separate tax-id number); or

2. A physician-owned single operating room in an office setting that is certified by Medicare.

"Ambulatory surgical case" means a procedure that is not minor surgery as defined in N.J.A.C. 13:35-4A.3 .

"Co-surgery" means two surgeons (each in a different specialty) are required to perform a specific procedure. Co-surgery also refers to surgical procedures involving

two surgeons performing the parts of one procedure simultaneously.

“CPT” means the American Medical Association’s Current Procedural Terminology, Fourth Edition, **Version 2006**, coding system. **Current Procedural Terminology (CPT) is copyright 2005 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 in the CPT. Applicable Federal Acquisition Regulation and Defense Federal Acquisition Supplement Regulation (FARS/DFARS), 48 CFR, restrictions apply to government use. CPT® is a trademark of the American Medical Association.**

...

“HCPCS” means the Federal [Health Care Financing Administration’s (HCFA’s)] **Center for Medicare and Medicaid Services (CMS)** Common Procedure Code System.

...

“Modifier” means an addition to the five-digit CPT code of either two letters or numbers that indicates that a service or procedure was performed that has been altered by some specific circumstance but not changed in its definition or code.

...

“Multiple surgeries” means additional procedures, unrelated to the major procedure and adding significant time or complexity, performed on the same patient at the same operative session or on the same day. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day.

...

“Powered traction device” means VAX-D, DRX or similar devices determined by the Federal Food and Drug Administration to provide traction services.

...

11:3-29.3 Regions

(a) Region I, as used in this subchapter, consists of **Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Monmouth, Ocean and Salem counties, which are comprised of** the following three- **and five-**digit zip codes in New Jersey: **077, 080, 081, 082, 083, [and] 084, 086, 087, 088 and 089. Region I also includes: 08502, 08504, 08512, 08528, 08530, 08536, 08551, 08553, 08556 through 08559 and 08570.**

(b) Region II, as used in this subchapter, consists of **Bergen, Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic, Somerset, Sussex, Union and Warren counties, which are comprised of** the following three- **and five-**digit zip codes in New Jersey: **070, 071, 072, 073, 074, 075, 076, [077,] 078[,] and 079[, 085, 086, 087, 088 and 089]. Region II also includes: 08501, 08505, 08510, 08511, 08514, 08515, 08518, 08520, 08525 through 08527, 08533 through 08535, 08541 through 08544, 08550, 08554, 08555 and 08560 through 08562.**

[(c) Region III, as used in this subchapter, consists of the following three-digit zip codes in New Jersey: 070, 071, 072, 073, 074, 075 and 076.]

11:3-29.4 Application of medical fee schedules

(a) Every policy of automobile insurance and motor bus insurance issued in this State shall provide that the automobile insurer's limit of liability for medically necessary

expenses payable under PIP coverage, and the motor bus insurer's limit of liability for medically necessary expenses payable under medical expense benefits coverage, is the fee set forth in this subchapter. Nothing in this subchapter shall, however, compel the PIP insurer or a motor bus insurer to pay more for any service or equipment than the [provider's] usual, customary and reasonable fee, even if such fee is well below the automobile insurer's or motor bus insurer's limit of liability as set forth in the fee schedules. [The fee schedules set forth at N.J.A.C. 11:3-29 Appendix, Exhibits 1 through 5, incorporated herein by reference, shall not apply to inpatient services provided by acute care hospitals, trauma centers, rehabilitation facilities, other specialized hospitals, residential alcohol treatment facilities and nursing homes, reimbursement of which shall be limited to the provider's usual, customary and reasonable fees.] The physicians' fee schedule at subchapter Appendix, Exhibit 1 shall not apply to services provided in [emergency care] **the trauma units** at Level I and Level II trauma hospitals. **Services subject to the exemption for trauma units shall use the modifier “-TU”.** **Surgical services (CPT 10000 through 69999) provided in emergency care in acute care hospitals that are not subject to the trauma care exemption shall be reimbursed at 150 percent of the physician’s fee schedule and shall use the modifier “-ER”.** Insurers [will] **are** not [be] required to pay for services or equipment that are not medically necessary.

(b) (No change.)

(c) The fees set forth in the schedule for durable medical equipment, subchapter Appendix, Exhibit 5, are retail prices which may include purchase prices for both new and used equipment, and/or monthly rentals. New equipment shall be distinguished with the use of modifier-NU, used equipment with modifier-UE and rental equipment with modifier-RR.

1. The insurer's total limit of liability for the rental of a single item of durable medical equipment set forth in the schedule is 15 times the monthly rental fee **or the purchase price of the item, whichever is less.**

(d) (No change.)

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

1. For the purposes of this subchapter, determination of the usual, reasonable and customary fee means that the provider submits to the insurer his or her usual and customary fee, that is, the amount that the provider is reimbursed for the service by all payors. The insurer determines the reasonableness of the provider's fee by comparison of its experience with that provider and with other providers in the region. The insurer may use national databases of fees, such as those published by Ingenix (www.ingenixonline.com) or Wasserman (<http://www.medfees.com/>), for example, to determine the reasonableness of fees for the provider's geographic region or zip code.

2. All applicable provisions of this section concerning billing and

payment apply to fees for services provided outside of New Jersey and to fees that are not on the fee schedule.

(f) [Except as provided in (m) below, the] **The** following shall apply to multiple and bilateral [procedures] **surgeries (CPT 10000 through 69999), co-surgeries and assistant surgeons:**

1. [When multiple or bilateral procedures are performed on the same patient by the same provider at the same time or during the same visit, it is virtually never appropriate for the fee to be the sum of the fees for each procedure. The primary procedure at a single session shall be paid at 100 percent of the eligible charge, the second procedure at no more than 50 percent of the upper limit in the fee schedule for that particular procedure, and if performed, any additional procedures at no more than 25 percent of the upper limits in the fee schedule for those particular procedures.] **For multiple surgeries, rank the surgical procedures in descending order by the fee schedule. The highest valued procedure is reimbursed at 100 percent of the eligible charge. Additional procedures are reported with the modifier “-51” and are reimbursed at 50 percent of the eligible charge. If any of the multiple surgeries are bilateral surgeries using the modifier “-50,” consider the bilateral procedure at 150 percent as one payment amount, rank this with the remaining procedures, and apply the appropriate multiple surgery reductions.**

2. [Procedure codes denoted as "each additional" are valued as listed and are not subject to the multiple and bilateral procedures guidelines.] **There are two types of procedures that are exempt from the multiple procedure reduction. Codes in CPT that have the note, “Modifier -51 exempt” shall be reimbursed at 100 percent of the eligible**

charge. In addition, some related procedures are commonly carried out in addition to the primary procedure. These procedure codes contain a specific descriptor that includes the words, “each additional” or “list separately in addition to the primary procedure.” These add-on codes cannot be reported as stand-alone codes but when reported with the primary procedure are not subject to the 50 percent multiple procedure reduction.

3. The terminology for some procedure codes includes the terms “bilateral or “unilateral or bilateral.” The payment adjustment rules for bilateral surgeries do not apply to procedures identified by CPT as “bilateral” or “unilateral or bilateral” since the fee schedule reflects any additional work required for bilateral surgeries. If a procedure is not identified by its terminology as a bilateral procedure (or unilateral or bilateral) and is performed bilaterally, providers must report the procedure with modifier “-50” as a single line item. Reimbursement for bilateral surgeries reported with the modifier “-50” shall be 150 percent of the eligible charge.

[3. If two or more providers in different specialties perform procedures or if one provider performs multiple procedures on different body parts or regions, each individual provider, or each individual body region or body part procedure may be reimbursed separately. For purposes of such billing, the body shall be divided into: head (including skull and brain); face; neck; chest; abdomen; back; and pelvic regions. In addition, the extremities shall be subdivided into right and left: upper arm, elbow, forearm, wrist and hand; and thigh, knee, lower leg, ankle and foot. This reference to specific body parts or regions is included as a guideline to be used in billings for operative and surgical procedures. It is not intended

to apply to nor should it be used in connection with billings submitted for non-surgical services provided during the same visit except as a means of describing the treatment rendered.]

4. For co-surgeries, each surgeon bills for the procedure with a modifier “-62”. For co-surgeries (modifier 62), the fee schedule amount applicable to the payment for each co-surgeon is 62.5 percent of the eligible charge.

[4. Nothing in this subchapter shall be construed to prevent PIP insurers or motor bus insurers from paying only reasonable and appropriate fees when multiple procedures are performed at the same time or multiple services provided during the same visit.]

5. The eligible charge for medically necessary assistant surgeon expenses shall be 20 percent of the primary physician's allowable fee determined pursuant to the fee schedule and rules. Assistant surgeon expenses shall be reported using modifier -80, -81 or -82 as designated in CPT. When the assistant surgeon is someone other than a physician surgeon, the reimbursement shall not exceed 85 percent of the amount that would have been reimbursed had a physician surgeon provided the service. Non-physician assistant surgeon services shall be reported using modifier-AS.

6. The necessity for co-surgeons and assistant surgeons for an operation shall be determined by reference to authorities such as the Medicare physician fee schedule database (www.cms.gov). Fees for assistant surgeons and co-surgeons are not rendered eligible for reimbursement simply because it is the policy of a provider or an ASC that one be present.

7. It is the responsibility of providers that are acting as co-surgeons

or assistant surgeons to include the correct modifier in their bills, especially as they may not be submitted to the insurer at the same time. If a surgeon submits a bill without a modifier and is paid 100 percent of the eligible charge and the insurer subsequently receives a bill from a co-surgeon or assistant surgeon for the same procedure, the insurer shall notify both providers that it has already paid 100 percent of the eligible charge and that it cannot reimburse the co-surgeon or assistant surgeon until the overpayment has been offset or refunded.

(g) Artificially separating or partitioning what is inherently one total procedure into subparts that are integral to the whole for the purpose of increasing medical fees is prohibited. Such practice is commonly referred to as "unbundling" or "fragmented" billing. [CPT 97010 (application of hot/cold packs) is bundled into the payment for other services and shall not be reimbursed separately.] **Providers and payors shall use the National Correct Coding Initiative Edits, incorporated herein by referenced, as updated quarterly by CMS and available at <http://www.cms.hhs.gov/physicians/cciedits/>.**

1. CPT 97010 (application of hot/cold packs) is bundled into the payment for other services and shall not be reimbursed separately.

2. 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 and CPT 76140 or for the physician component of the imaging study. CPT 76140 may only be billed where a provider in a different practice or facility reviews an imaging study and produces a written report.

3. When CPT 76005, fluoroscopic guidance, can be billed separately and is not included as part of another procedure, it is reimbursable only per spinal region, not per level.

4. Appendix J of the CPT manual, Electrodiagnostic Medicine Listing of Sensory, Motor and Mixed Nerves may be used as a reference for the appropriate reimbursement of this type of Electrodiagnostic testing.

5. Moderate (conscious) sedation performed by the physician who also furnishes the medical or surgical service cannot be reimbursed separately. 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 reimbursable.

6. CPT codes 99148 through 99150 are only reimbursable when a second physician other than the provider performing the diagnostic or therapeutic services provides moderate sedation in a facility setting (for example, hospital, outpatient hospital/ambulatory surgery center or skilled nursing facility). CPT codes 99148 through 99145 are not reimbursable for services performed by a second physician in a physician office, freestanding imaging center or for any procedure code identified in CPT as including moderate (conscious) sedation.

(h) To be reimbursable, nerve conduction studies (NCS) (CPT 95900 through 95904) must be interpreted by a physician who was on site and directly supervised or performed the nerve conduction study. Needle EMG interpretation must be performed in the same facility on the same day by the same physician who performed and/or supervised the nerve conduction studies.

(i) The reporting of Nerve Conduction Studies and Needle

Electromyography (EMG) (CPT 95860-95872) results should be integrated into a unified diagnostic impression. Separate reports for needle EMG and NCS are not reimbursable under the codes above.

[(h)](j) (No change in text.)

[(i)](k) CPT codes for unlisted procedures or services **that are not on the fee schedule** (example: [97139 Unlisted therapeutic procedure]**#64999 Unlisted procedure nervous system**) are not reimbursable without documentation **from the provider** describing the procedure or service performed, demonstrating its medical appropriateness and indicating why it is not duplicative of a code for a listed procedure or service. **Documentation may include the existence of temporary or AMA Category III or HCPCS codes for the procedure or information in the AMA CPT Assistant publication. In submitting bills for unlisted codes, the provider should base the fee on a comparable procedure. It is never appropriate for the provider to bill an unlisted code for a list of services that have CPT codes. Providers that intend to use unlisted codes in non-emergency situations are encouraged to notify the insurer in advance through the precertification process. Based on the information submitted by the provider, the insurer shall determine whether the CPT coding is appropriate.**

[(j) The insurer's limit of liability for medically necessary assistant surgeon expenses shall be 20 percent of the primary physician's allowable fee determined pursuant to the fee schedule and rules. Assistant surgeon expenses shall be reported using modifier -80, -81 or -82 as designated in CPT. When the assistant surgeon is someone other than a physician surgeon, the reimbursement shall not exceed 85 percent of the amount that would have been reimbursed had a physician surgeon provided the service. These services shall

be reported using modifier-AS as designated in HCPCS.

(k) When two physician surgeons are required for a specific surgical procedure, the separate services claimed by each surgeon shall be reported using the modifier -62 as designated in CPT. Total eligible expense shall equal 150 percent of a single practitioner's eligible expense amount for the surgical procedure performed, to be divided equally between the two surgeons.]

(l) [The professional component of global service charges shall be reported using modifier -26 as designated in CPT.] **Certain CPT codes are listed in the fee schedule with three entries. There is a global fee with no modifier, a technical component with modifier "TC" and a physician component with modifier "-26".** Services with [professional] **physician** component amounts of zero in the fee schedule are considered to be 100 percent technical. [The technical component is the difference between the global service and the professional component amounts listed in the fee schedule.] **A provider shall not bill the global fee and a technical or physician component. The technical or physician component shall be billed when only that part of the service is being provided.**

(m) The daily maximum allowable fee shall be [\$90.00] **\$99.00** for the Physical Medicine and Rehabilitation CPT codes listed in subchapter Appendix, Exhibit 6, incorporated herein by reference, that are commonly provided together. The daily maximum applies when such services are performed for the same patient on the same date. **The daily maximum applies to all providers, including dentists.** However, [an insurer is not prohibited from reimbursing providers in excess of the daily maximum where] **when the provider can demonstrate that** the severity or extent of the injury is such that

extraordinary time and effort is needed for effective treatment, **the insurer shall reimburse in excess of the daily maximum.** Such injuries could include, but are not limited to, severe brain injury and non-soft-tissue injuries to more than one part of the body. **Such injuries would not include diagnoses for which there are care paths in N.J.A.C. 11:3-4.** Treatment that the provider believes should not be subject to the daily maximum shall be billed using modifier-22 as designated in CPT for unusual procedural services. Unless already provided to the insurer as part of a decision point review or precertification request, the billing shall be accompanied by documentation of why the extraordinary time and effort for treatment was needed.

[(n)] **1.** (No change in text.)

2. CPT 97012 is the appropriate code for billing powered traction therapy.

3. CPT 97026 is the appropriate code for billing cold or low-powered laser therapy.

4. HPCPS code G0283 is the appropriate code for billing unattended electrical stimulation.

5. Pursuant to N.J.S.A. 39:6A-4, physical therapy, as defined in N.J.S.A. 45:9-37.13, shall not be reimbursable under PIP unless rendered by a licensed physical therapist pursuant to a referral from a licensed physician, dentist, podiatrist or chiropractor within the scope of the respective practices.

[(o)](n) (No change in text.)

(o) ASC facility fee group numbers are indicated by CPT code on the physician's fee schedule, subchapter Appendix, Exhibit 1. The facility fees for each

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

1. Use of operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use to persons accompanying the patient.

2. All services and procedures in connection with covered procedures furnished by nurses, technical personnel and others involved in patient's care;

3. Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment;

4. Diagnostic and therapeutic items and services;

5. Administrative, recordkeeping, and housekeeping items and services;

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.

(p) The following services are not included in the ASC facility fee:

1. The sale, lease or rental of durable medical equipment (DME) to ASC patients for use in their homes. If the ASC 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, including neuro-stimulators, internal/external fixators, tissue grafts, plates, screws, anchors and wires, whether implanted, inserted, or otherwise applied by covered surgical procedures. Such prosthetics and devices shall be billed at invoice plus 20 percent.

(q) When multiple procedures are performed in an ASC in the same operative session, the ASC facility fee for the procedure with the highest payment group number is reimbursed at 100 percent and reimbursement of any additional procedures furnished in the same session is 50 percent of the applicable facility fee. For example, if two Group 2 procedures and a Group 1 procedure are all performed in the same operative session, reimbursement of the ASC facility fee is 100 percent of the first Group 2 fee plus 50 percent of the second Group 2 fee, plus 50 percent of the Group 1 fee.