

SUBCHAPTER 29. MEDICAL FEE SCHEDULES: AUTOMOBILE INSURANCE
PERSONAL INJURY PROTECTION AND MOTOR BUS MEDICAL EXPENSE
INSURANCE COVERAGE

11:3-29.1 Purpose and scope

(a) 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 or the usual, customary and reasonable fee, whichever is less.

(b) This subchapter implements the provisions of N.J.S.A. 39:6A-4.6 to establish medical fee schedules on a regional basis for the reimbursement of health care providers providing services or equipment for medical expense benefits for which payment is required to be made by automobile insurers under PIP coverage and by motor bus insurers under medical expense benefits coverage.

(c) This subchapter applies to all insurers who issue policies of automobile insurance containing PIP coverage and policies of motor bus insurance containing medical expense benefits coverage.

(d) This subchapter does not apply to the following:

1. Other coverages contained in an automobile or motor bus insurance policy such as coverage for bodily injury liability;
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;

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, except as specifically set forth in this subchapter.

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, 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 procedures that is not minor surgery as defined in N.J.A.C. 13:35-4A-3.

"Basic Life Support" ("BLS") means volunteer ambulance services, whose personnel are not required to be Emergency Medical Technicians, and municipal and proprietary ambulance services whose personnel are required to be Emergency Medical Technicians.

"Bilateral surgery" means identical procedures (requiring use of the same CPT code) performed on the same anatomic site but on opposite sides of the body. Furthermore, each procedure is performed through its own separate incision.

"CDT" means the American Dental Association's Current Dental Terminology 2011-2012, copyright 2010.

"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 2011, coding system. Current Procedural Terminology (CPT) is copyright 2011 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 Regulation Supplement (FARS/DFARS), 48 CFR, restrictions apply to government use. CPT[®] is a trademark of the American Medical Association.

"Eligible charge or expense" means the usual, customary and reasonable charge as determined pursuant to N.J.A.C. 11:3-29.4(e)1 or the upper limit in the fee schedule, whichever is lower.

"Emergency care" means all medically necessary treatment of a traumatic injury or a medical condition manifesting itself by acute symptoms of sufficient severity such that absence of immediate attention could reasonably be expected to result in: death; serious impairment to

bodily functions; or serious dysfunction of a bodily organ or part. Such emergency care shall include all medically necessary care immediately following an automobile accident, including, but not limited to, immediate pre-hospitalization care, transportation to a hospital or trauma center, emergency room care, surgery, critical and acute care. Emergency care extends during the period of initial hospitalization until the patient is discharged from acute care by the attending physician.

"Global service" means the sum of the technical and professional components.

"HCPCS" means the Federal Center for Medicare and Medicaid Services (CMS) Common Procedure Code System.

"Health care provider" or "provider" is as defined in N.J.A.C. 11:3-4.

"Health insurance" means a contract or agreement whereby an insurer is obligated to pay or allow a benefit of pecuniary value with respect to the bodily injury, disability, sickness, death by accident or accidental means of a human being, or because of any expense relating thereto, or because of any expense incurred in prevention of sickness, and includes every risk pertaining to any of the enumerated risks. As used in this subchapter, health insurance includes workers' compensation coverage but does not include any PIP coverage.

"Health insurer" includes any insurer issuing a policy of health insurance as defined in this subchapter.

"Hospital" means a general acute care hospital, a long-term acute care hospital or a comprehensive rehabilitation hospital.

"Hospital outpatient surgical facility" or "HOSF" means a facility where hospital outpatients are treated.

“Hospital outpatient” means a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital. When a patient with a known diagnosis enters a hospital for a specific surgical procedure or other treatment that is expected to keep him or her in the hospital for only a few hours (less than 24), he or she is considered an outpatient for coverage purposes regardless of the hour he or she came to the hospital; whether he or she used a bed; or whether he or she remained in the hospital past midnight.

"Medically necessary" or "medical necessity" means that:

1. The medical treatment or diagnostic test is consistent with the clinically supported symptoms, diagnosis or indications of the injured person;
2. The treatment is the most appropriate level of service that is in accordance with the standards of good practice and the provisions of N.J.A.C. 11:3-4, as applicable;
3. The treatment is not primarily for the convenience of the injured person or provider;
4. The treatment is not unnecessary; and
5. The treatment does not include unnecessary testing.

"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.

"Motor bus" means motor bus as defined in N.J.S.A. 17:28-1.5.

"Motor bus insurer" includes any insurer issuing a policy of insurance on a motor bus the owner, registered owner, or operator of which is required to maintain medical expense benefits coverage pursuant to N.J.S.A. 17:28-1.6.

"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.

"PIP coverage" means personal injury protection coverage described in N.J.S.A. 39:6A-3.1(a), 39:6A-4a and 39:6A-10 as amended.

"PIP insurer" includes any insurer issuing a policy of automobile insurance on any vehicle that contains PIP coverage.

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

"Three-digit zip code" refers to the first three digits of the U.S. postal code.

"Trauma services" means the care provided in the Level I or Level II trauma hospital to patients whose arrival requires trauma center activation. It does not include transportation to the hospital, treatment of patients whose arrival at the hospital does not require trauma activation or outpatient visits after a patient who has received trauma care is discharged from acute care.

11:3-29.3 Regions

(a) The Regions in Appendix, Exhibit 1, Physicians' Fee Schedule, Exhibit 2, Dental Fee Schedule and Exhibit 4, Ambulance Services, are as follows:

1. South Region consists of Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Monmouth, Ocean and Salem counties, which are comprised of the following three- and five-digit zip codes in New Jersey: 077, 080, 081, 082, 083, 084, 086 and 087. The South Region also includes: 08501, 08505, 08510, 08511, 08514 through 08527, 08533 through 08535, 08540 through 08550, 08554, 08555 and 08560 through 08562.

2. North Region consists of Bergen, Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic, Somerset, Sussex, Union and Warren counties, which are comprised of the following three- and five-digit zip codes in New Jersey: 070, 071, 072, 073, 074, 075, 076, 078, 079, 088 and 089. The North Region also includes: 08502, 08504, 08512, 08528, 08530, 08536, 08551, 08553, 08556 through 08559 and 08570.

11:3-29.4 Application of medical fee schedules

(a) Nothing in this subchapter shall compel the PIP insurer or a motor bus insurer to pay more for any service or equipment than the usual, customary and reasonable fee, even if such fee is well below the automobile insurer's or motor bus insurer's limit of liability as set forth in the fee schedules. Insurers are not required to pay for services that are not medically necessary.

1. The fees for physicians' services in subchapter Appendix, Exhibit 1 the provisions in (f) 1 through 7 below and the non-physician facility fees in subchapter Appendix, Exhibit 7 shall not apply to trauma services at Level I and Level II trauma hospitals. Bills for services subject to the trauma services exemption shall use the modifier "-TS".

2. The non-physician facility fees in subchapter, Appendix, Exhibit 7 shall not apply to services provided in hospital emergency rooms. The bills for these services shall use the modifier "-ER".

3. The physician fees for 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 physicians' fees in subchapter Appendix, Exhibit 1. The bills for these services shall use the modifier "-ER".

4. Except as provided in (a)1 through (3) above, the fees in Appendix, Exhibits 1 through 7 apply regardless of the site of service.

(b) The region used to determine the proper fee set forth in the schedules shall be determined by the region in which the services were rendered or the equipment was provided or, in the case of elective services or equipment provided to New Jersey residents outside the State, by the region in which the insured resides.

(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.

2. For the provision and billing of durable medical equipment, payors shall follow the relevant provisions of Chapter 20 of the Medicare Claims Processing Manual, updated periodically by CMS and incorporated by reference, that were in effect at the time the service was provided (<http://www.cms.gov/manuals/downloads/clm104c20.pdf>).

(d) The insurer's limit of liability for any medical expense benefit for service or equipment provided outside the State of New Jersey shall be as follows:

1. When the service or equipment is provided by reason of emergency or medical necessity, the reasonable and necessary costs shall not exceed fees that are usual, customary and reasonable for that provider in the geographic location where the service or equipment is provided.

2. When the service or equipment is provided by reason of the election by the insured to receive treatment outside the State of New Jersey, the reasonable and necessary costs shall not exceed fees set forth in the fee schedules for the geographic region in which the insured resides.

(e) Except as noted in (e)1 through 3 below, the insurer's limit of liability for any medical expense benefit for any service or equipment not set forth in or not covered by the fee schedules shall be a reasonable amount considering the fee schedule amount for similar services or equipment in the region where the service or equipment was provided or, in the case of elective services or equipment provided outside the State, the region in which the insured resides. When a CPT, CDT or HCPCS code for the service performed has been changed since the fee schedule rule was last amended, the provider shall always bill the actual and correct code found in the most recent version of the American Medical Association's Current Procedural Terminology or the American Dental Association's Current Dental Terminology. The amount that the insurer pays for the service shall be in accordance with this subsection. Where the fee schedule does not contain a reference to similar services or equipment as set forth in the preceding sentence, the insurer's limit of liability for any medical expense benefit for any service or equipment not set forth in the fee schedules shall not exceed the usual, customary and reasonable fee.

1. 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

by means of explanations of benefits from payors showing the provider's billed and paid fee(s). 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. National databases of fees, such as those published by FAIR Health (www.fairhealthus.org) or Wasserman (<http://www.medfees.com/>), for example, are evidence of the reasonableness of fees for the provider's geographic region or ZIP code. The use of national databases of fees is not limited to the above examples. When using a database as evidence of the reasonableness of a fee, the insurer shall identify the database used, the edition date, the geozip and the percentile.

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.

3. Codes in Appendix, Exhibit 1 that do not have an amount in the ASC facility fee column are not reimbursable if performed in an ASC and are not subject to the provision in (e) above concerning services not set forth in or covered by the fee schedules.

(f) Except as specifically stated to the contrary, the following shall apply to physician charges for multiple and bilateral surgeries (CPT 10000 through 69999), co-surgeries and assistant surgeons:

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

2. 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.

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.

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 outpatient surgical facility 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.

8. Prosthetic and other devices, including neuro-stimulators, internal/external fixators, single use spine wands and spine probes, tissue grafts, plates, screws, anchors and wires, whether implanted, inserted, or otherwise applied by covered surgical procedures shall be reimbursed at no more than the invoice for the device plus 20 percent. This provision applies regardless of where the procedure is performed, including trauma centers, hospital emergency rooms, inpatient surgeries and outpatient surgical facilities.

(g) Except as specifically stated to the contrary in this subchapter, the fee schedules shall be interpreted in accordance with the following, incorporated hererin by reference, as amended and supplemented: the relevant chapters of the Medicare Claims Processing Manual, updated

periodically by CMS, that were in effect at the time the service was provided. The Medicare Claims Processing Manual is available at

<https://www.cms.gov/Manuals/IOM/itemdetail.asp?itemID=CMS018912>; the NCCI Policy

Manual for Medicare Services, as updated periodically by CMS and available at

http://www.cms.gov/NationalCorrectCodInitEd/Downloads/NCCI_Policy_Manual.zip; Modifier

59 Article: Proper Usage Regarding Distinct Procedural Service, available from CMS at

<https://www.cms.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf>; and the CPT

Assistant available from the American Medical Association (www.AMAbookstore.com).

1. Artificially separating or partitioning what is inherently one total procedure into subparts that are integral to the whole for the purpose of increasing medical fees is prohibited. Such practice is commonly referred to as “unbundling” or “fragmented” billing. Providers and payors shall use the National Correct Coding Initiative (NCCI) Edits, incorporated herein by reference, as updated quarterly by CMS and available at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>. Modifier 59 and other NCCI-associated modifiers should not be used to bypass an NCCI edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used. For more information on the criteria for the use of modifiers, see the NCCI Policy Manual and Modifier 59 Article referenced in (g) above.

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

3. X-ray digitization or computer aided radiographic mensuration reported under CPT 76499 or any other code are not reimbursable under PIP.

4. Kinesio taping or other taping is not reimbursable under PIP. Kinesio taping shall not be billed using the strapping codes, CPT 29200 through 29280 and 29520 through 29590.

5. Platelet Rich Plasma (PRP) injections are only reimbursable for treatment of chronically injured tendons that have failed to improve despite appropriate conservative treatments. PRP injections shall be billed under code 0232T in subchapter Appendix, Exhibit 1.

6. Leads, pads, batteries and any other supplies for use of TENS or EMS devices are included in the fee for the rental of the unit and are not separately reimbursable when rented. For purchase of the unit, the first month's supply of leads, pads, batteries and any other supplies for TENS or EMS units are included.

7. The eligible charge for an office visit includes reviewing the report of an imaging study when the provider of the imaging study has billed for the technical and professional component of the service. In these circumstances, it is not appropriate for the provider to bill for an office visit, CPT 76140 or for the physician component of the imaging study. CPT 76140 is not reimbursable. Where a provider in a different practice or facility performs a medically necessary review of an imaging study and produces a written report as part of a consultation, the provider shall bill the professional component (modifier -26) for each specific radiology service.

8. When CPT 77003, 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.

9. HCPCS code G0289 is an add-on code and should be added to the knee arthroscopy code for the major procedure being performed. This code is only to be reported once per extra compartment, even if chondroplasty, loose body removal and foreign body removal are all performed. The code may be reported twice if the physician performs these procedures in two compartments in addition to the compartment where the main procedure was performed.

i. This code shall be reported only when the physician spends at least 15 minutes in the additional compartment performing the procedure. It shall not be reported if the reason for performing the procedure is due to a problem caused by the arthroscopic procedure itself. This code is to be used when a procedure is performed in the lateral, medial, or patellar compartments in addition to the main procedure. The billing of CPT codes 29874 and 29877 is not permitted with other arthroscopic procedures on the same knee and CPT code 29874 shall not be used to report the services described by code G0289.

10. 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.

11. Moderate (conscious) sedation performed by the physician who also furnishes the medical or surgical service cannot be reimbursed separately for the procedures listed in Appendix G of the CPT manual. In that case, payment for the sedation is bundled into the payment for the medical or surgical service. As a result, CPT codes 99143 through 99145 are not reimbursable for the procedures in Appendix G of the CPT manual.

12. CPT codes 99148 through 99150 are only reimburseable 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 99150 are not reimburseable 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.

13. CPT 22505, “Manipulation of spine requiring anesthesia, any region,” if medically necessary, can only be reported once for any and all regions manipulated on that date.

(h) To be reimbursable, nerve conduction studies (NCS) (CPT 95900 - 95904) must be interpreted by a provider who was on site and directly supervised or performed the nerve conduction study in accordance with N.J.A.C. 13:35-2.6(n)3. Needle Electromyography (EMG) interpretation must be performed in the same facility on the same day by the same physician who performed and/or supervised the needle EMG.

(i) The reporting of nerve conduction studies and needle electromyography (EMG) (CPT 95860 through 95872) results should be integrated into a unified diagnostic impression. Separate reports for needle EMG and NCS are not reimbursable under the codes above in this subsection.

(j) For surgery and many other procedures, it is established practice to include follow-up care and visits as part of the basic procedure charge. Such charges shall not be subject to additional billings. The existence of a CPT code, per se, does not imply the right to receive separate compensation for the procedure/sub-procedure so described. If a procedure is judged to be part of the primary procedure, only the charges for the primary procedure are eligible. As identified in CPT, separate procedures are commonly carried out as an integral part of another procedure. They shall not be billed in conjunction with the other procedure, but may be billed when performed independently of the other procedure.

(k) CPT codes for procedures described in CPT as "unlisted procedure" or "unlisted service" (example: 64999 Unlisted procedure nervous system) are not reimbursable without documentation from the provider describing the procedure or service performed, demonstrating its medical appropriateness and indicating why it is not duplicative of a code for a listed procedure or service. Documentation may include the existence of temporary or AMA Category III or HCPCS codes for the procedure or information in the AMA CPT Assistant publication. In submitting bills for unlisted codes, the provider should base the fee on a comparable procedure.

It is never appropriate for the provider to bill an unlisted code for a list of services that have CPT codes. Providers that intend to use unlisted codes in non-emergency situations are encouraged to notify the insurer in advance through the precertification process. Based on the information submitted by the provider, the insurer shall determine whether the CPT coding is appropriate.

(l) 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 physician component amounts of zero in the fee schedule are considered to be 100 percent technical. 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 \$105.00 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. In determining whether a provider has reached the daily maximum, the insurer shall apply the NCCI edits. The daily maximum applies to all providers, including dentists. However, 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.

1. Supervised modalities and those therapeutic procedures that do not list a specific time increment in their description shall be limited to one unit per day.

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.

(n) Follow-up evaluation and management services for the re-examination of an established patient shall be reimbursed in addition to physical medicine and rehabilitation procedures only when any of the circumstances set forth in (n)1 through 4 below is present and not more than twice in any 30-day period. Modifier -25 shall be added to an evaluation and management service when a significant separately identifiable evaluation and management service is provided and documented as medically necessary as follows:

1. There is a definite measurable change in the patient's condition requiring significant change in the treatment plan;

2. The patient fails to respond to treatment, requiring a change in the treatment plan;

3. The patient's condition becomes permanent and stationary, or the patient is ready for discharge; or

4. It is medically necessary to provide evaluation services over and above those normally provided during the therapeutic services.

(o) Regardless of the specific codes that are included in a DPR/Precertification request, the insurer's reimbursement for those services shall be consistent with the rules contained in this subchapter, including the NCCI edits and the CPT Manual current at the time the services were provided.

(p) The ANES code on the Physicians' Fee Schedule is the conversion factor for anesthesia units. Payors shall follow the Medicare Claims Processing Manual and other guidelines for calculating the number of units for the various CPT codes for the administration of anesthesia and other billing situations, such as directing or supervising Certified Nurse Anesthetists and other non-physician anesthesia providers. These can be found at:

www.cms.hhs.gov/center/anesth.asp.

11:3-29.5 Outpatient surgical facility fees

(a) ASC facility fees are listed in Appendix, Exhibit 1, by CPT code. Codes that do not have an amount in the ASC facility fee column are not reimbursable if performed in an ASC. The ASC facility fee include services that would be covered if the services 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 the patient's care;

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

4. Diagnostic and therapeutic items and service. Appendix, Exhibit 1 indicates those CPT codes that, according to Medicare (see: www.cms.gov/ASCPayment/ASCRN/list.asp, CMS-1504-FC, Exhibit AA), are considered ancillary services that are integral to surgical procedures and are not permitted to be reimbursed separately in an ASC. Appendix, Exhibit 7 indicates those services that, according to Medicare are considered ancillary services that according to Medicare (see:

https://www.cms.gov/HospitalOutpatientPPS/Downloads/CMS1506FC_Addendum_D1.pdf) are integral to surgical procedures and are not permitted to be reimbursed separately in a HOSF;

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

6. Blood, blood plasma, platelets, etc.;

7. Anesthesia materials, including the anesthetic itself, and any materials, whether disposable or re-usable, necessary for its administration; and

8. Implantable DME and prosthetics.

(b) HOSF fees are listed on subchapter Appendix, Exhibit 7 by CPT code. The hospital outpatient surgical facility fee is the maximum that can be reimbursed for outpatient procedures performed in an HOSF. The hospital outpatient facility fees in Appendix Exhibit 7 include services that would be covered if furnished in a hospital on an inpatient basis, including those set forth in (a)1 through (8) above.

(c) The sale, lease or rental of durable medical equipment (DME) to patients for use in their homes are not included in the ASC or HOSF fee. If the ASC or HOSF furnishes items of DME to patients, billing for such items should be made in accordance with subchapter Appendix, Exhibit 5.

(d) When multiple procedures are performed in an in an ASC or in an HOSF in the same operative session, the ASC facility fee or the HOSF fee, as applicable, for the procedure with the highest payment amount is reimbursed at 100 percent and reimbursement of any additional procedures furnished in the same session is 50 percent of the applicable facility fee.

1. A procedure performed bilaterally in one operative session is reported as two procedures and is subject to the multiple procedure reduction formula.

2. Subchapter, Appendices, Exhibit 1, the Physicians' and ASC Facility Fee Schedule and Exhibit 7, the HOSF fee schedule, indicate those CPT codes that, according to Medicare (see: www.cms.gov/ASCPayment/ASCRN/list.asp and <http://www.cms.gov/HospitalOutpatientPPS/>), are exempt from the multiple procedure reduction formula.

11:3-29.6 Balance billing prohibited

No health care provider may demand or request any payment from any person in excess of those permitted by the medical fee schedules and this subchapter, nor shall any person be liable to any health care provider for any amount of money that results from the charging of fees in excess of those permitted by the medical fee schedules and this subchapter.

