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BULLETIN NO. 10-30

TO: **ALL NEW JERSEY PRIVATE PASSENGER AUTOMOBILE INSURERS AND MOTORBUS INSURERS AND THE NATIONAL ARBITRATION FORUM**

FROM: **THOMAS B. CONSIDINE, COMMISSIONER**

RE: **INTERPRETATION OF DOBI RULES ON PIP REIMBURSEMENTS**

It has come to the Department's attention that some Dispute Resolution Professionals (DRPs) have issued decisions that disregard our administrative rules. The purpose of this Bulletin is to identify some examples of this practice and to remind insurers, the Department's PIP arbitration vendor and DRPs that, in accordance with N.J.A.C. 11:3-5.4(a)8, the determinations of the DRPs shall be fair, efficient and consistent with substantive law and the Department's rules for the handling of PIP claims.

Usual, Customary and Reasonable (UCR) Fees: Many DRPs incorrectly assert that UCR fees can be demonstrated by simply reviewing examples of provider invoices. The DRPs who do so frequently rely upon language from *Cobo vs. Mkt Transition Facility*, 293 N.J. Super. 374 (App. Div. 1996) as the authority for this position. This is legally incorrect and ignores the fact that through amendments to the PIP Medical Fee Schedule rule adopted subsequent to *Cobo*, the Department established a different process for how UCR is to be calculated. The Department's rule at N.J.A.C. 11:3-29.4(e)1 clearly states that the provider is to submit his or her usual and customary fee for the service and it is the insurer, not the provider, that is to determine reasonableness. The rule was upheld by the Appellate Division (*In Re Adoption of N.J.A.C. 11:3-29 by the State of New Jersey, Department of Banking and Insurance*, 410 N.J. Super. 6, 48-55 (App. Div. 2009)), and clearly permits insurers to use national databases to determine the reasonableness of a provider's usual and customary fee. Further, in accordance with the Appellate Division's decision, the Department in Order A10-113 concluded that the Ingenix MDR database can be used by insurers to determine the reasonableness of fees that are not on the fee schedule. Therefore, DRPs should be following this new procedure for determining the appropriate UCR reimbursement.

Use of Insurer's Internal Appeals Process prior to filing for arbitration: A number of DRPs have stated that there is no authority in statute, the Administrative Code or in case law that would permit the insurer to bar providers from access to the statutorily created dispute resolution

process based upon the failure of the provider to comport with what one DRP described as, "the unexplained terms and conditions of an internal appeals process established by, shaped by, managed by and governed by the respondent carrier." These DRPs have described the internal appeal process as an "arbitrarily determined procedure." Other DRPs have opined that the only "penalty" permitted by the Decision Point Review plan is a penalty deductible, not denial of a payment for a claim. Still other DRPs have decided that it is "unreasonable" to dismiss a provider's demand for arbitration for failure to submit an internal appeal within the required time frames in the insurer's Decision Point Review Plan.

These arguments are contrary to the whole purpose of the appeals process and the Department's rules. In N.J.A.C. 11:3-4.9(a)1, the Department permits insurers, as part of an insureds' assignments of benefits to providers, to require the providers to comply with all requirements of the Decision Point Review plans. Moreover, N.J.A.C. 11:3-4.7(c)6 requires insurers' Decision Point Review plans to contain an internal appeals process and such plans may require that the internal appeals process be exhausted prior to the initiation of PIP arbitration. These limited restrictions on the assignment of benefits do not deny payment of a claim or prohibit a provider from accessing the statutorily mandated external dispute resolution process. They merely establish a prerequisite for doing so. It is only reasonable and logical for insurers' to require that, before using the expensive and lengthy external dispute resolution process, an insured or a provider under assignment should first utilize the insurer's internal appeals process. The internal and external appeal processes established by the Department for health care follow this pattern. Thus, where a provider agrees in an Assignment of Benefits to follow the requirements of the Decision Point Review plans, the provider also agrees to comply with the insurer's internal appeals process contained therein, and with any penalties imposed in the plan for failure to comply with the internal appeals process.

Application of the Multiple Procedures Reduction Formula for CPT codes 10000 to 69999: Some DRPs have decided that some codes within this range, in particular, 62290 and 62291, are diagnostic and not surgical procedures and therefore are not subject to the multiple procedure reduction formula. Other DRPs have decided that, although the Department stated that the multiple procedures reduction formula does not apply to codes designated in CPT as "each additional," this does not mean that codes without the "each additional" designation are necessarily subject to the multiple procedures reduction formula.

In N.J.A.C. 11:3-29.4(f), the Department states clearly that surgical codes are subject to the multiple procedures reduction formula and defines those codes as CPT codes 10000 through 69999. It is a violation of the rule for DRP's to arbitrarily decide that some codes in that range are not surgical or are not subject to the multiple procedures reduction formula. Similarly, the rule expressly states that the only codes not subject to the multiple procedures reduction formula are those CPTs: 1) that have the note of "Modifier -51 exempt;" or, 2) that contain a specific descriptor that includes the words "each additional" or "list separately in addition to the primary procedure." N.J.A.C. 11:3-29.4(f)2. The express language of the rule, and the most elementary principles of statutory construction interpreting same, clearly indicate that any codes not so designated are subject to the multiple procedure reduction formula.

October 28, 2010

Date

Thomas B. Considine
Commissioner

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