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January 10, 2008

Summary: MAXIMUS has determined that additional reimbursement is warranted for the CPT codes at issue in this arbitration for the date of service 5/22/07 in the amount of $12,972.30 with payment to be made by the Payer to the Provider.

MAXIMUS Case File Number: NJ07-0255
Enrollee Name:
Plan: Small Employer
Payer:
Provider:
Date(s) of Service: 5/22/07

Dear :

On 8/24/07, you filed a Request for Arbitration pursuant to the New Jersey Health Claims Authorization, Processing and Payment Act. This arbitration filing was related to a claims appeal you filed with on 8/2/07. We, MAXIMUS, are under contract with the New Jersey Department of Banking and Insurance to make Arbitration decisions in appeals such as yours. This means we employ health care claims professionals who study your case file and claims records to arbitrate the claims you have in dispute with . MAXIMUS and all of our arbitrators are impartial and independent. We have no material affiliations with any health care provider, facility or Payer in the state of New Jersey.

Case File Summary:

A Provider is seeking additional reimbursement for CPT codes 29879 and 29873-59 performed on 5/22/07. The Payer has denied this request indicating it has already reimbursed the provider a reasonable amount and for the CPT codes at issue and has denied the provision of additional reimbursement to the provider. In addition, the provider is not contracted with the Payer and the Payer indicates it has already reimbursed the provider over and above the Payer's allowance for non-contracted providers. According to the Payer, it updated its out-of-network allowance for reimbursement of non-participating New Jersey ambulatory surgery center services in July 2005. The Health Plan indicates, its updated out-of-network allowance was developed by a nationally recognized consulting firm specializing in health care payment methodologies and that this

allowance places the payment range considerably above Medicare and within close range of median payments by commercial payers, as reported by a third party data collection organization. Within the submission of its arbitration information, the Payer did not provide any data or information from the two organizations the Payer referenced.

On 9/18/07, the Payer submitted a letter to MAXIMUS indicating the Provider's request was not qualified for arbitration because the Provider had not submitted a first level appeal to the Payer prior to the Provider requesting an arbitration. However, MAXIMUS informed the Payer that appropriate evidence demonstrating the Provider had submitted a first level appeal had been submitted to MAXIMUS and that the Provider's request did qualify for arbitration. In fact, MAXIMUS has a copy of the Payer's denial of the Provider's first level appeal. On 10/26/07, the Payer submitted payment and documentation for MAXIMUS to proceed with the arbitration. On 10/30/07, the Payer submitted a letter to MAXIMUS indicating the Payer had initially processed the codes at issue improperly and as a result the claim associated with the codes was in the process of being adjusted to reimburse the full amount of the claim to the Provider minus any applicable copayments. This information was submitted to the Provider. In response Provider informed MAXIMUS that the Provider did not want to terminate the arbitration.

A review of the record indicates the Provider submitted the following billed charges for the following CPT codes:

1. CPT code 29879 Provider billed $8,194.82 Payer reimbursed $305.70
2. CPT code 29873-59 Provider billed $6,266.70 Payer reimbursed $305.70

The Provider believes the Payer has the burden of demonstrating the Provider's billed charges are unreasonable.

At issue in this arbitration is whether additional reimbursement for the CPT codes at issue is reasonable and appropriate and consistent with the enrollee's out-of-network benefit.

Analysis and Findings:

Additional reimbursement to the Provider is warranted for CPT Codes 29879 and 29873-59 in this case.

Based upon the information provided by both parties to the arbitration and review of the Ingenix Prevailing Healthcare Charge System (PHCS), MAXIMUS has determined the Provider should receive additional reimbursement for the codes at issue. In this case, the Payer has not provided detailed objective information establishing why the amount it has reimbursed the Provider is considered reasonable. Therefore, an out-of-network benefit was not discernable. Records submitted demonstrate that the enrollee's plan in this matter is defined as a small employer plan [ ]. According to the New Jersey Administrative Code §11:21-7.13, in paying benefits for covered services under the terms of the small employer health benefits plan provided by health care providers not subject to capitated or negotiated fee arrangements, small employer carriers shall pay covered charges for medical services, on a reasonable and customary basis or actual charges. Reasonable and customary means a standard based on the Ingenix

Prevailing Healthcare Charge System (PHCS) profile for New Jersey. This section of the New Jersey Administrative Code further stipulates that the maximum allowable charge shall be based on the 80th percentile of the PHCS profile. Based upon this information, the Provider should be reimbursed the lesser of the actual billed charges or the amount set by the 80th percentile of PHCS for CPT codes 29879 and 29873-59.

In this case, the 80th percentile of PHCS for code 29879 is $7,317 (Provider's billed charges were $8,194.82) and the 80th percentile of PHCS for code 2983-59 is $7,317 (Provider's billed charges were $6,266.70).

The chart below provides a comparison of billed charges and reimbursement rates for the codes and dates of services at issue.

CPT Service Code	Provider Billed	Plan Reimbursed	80th Percentile PHCS	MAXIMIS Recommended Reimbursement
Date of Service: 5/22/07				
29879	$8,194.82	$305.70	$7,317.00	$7,011.30
29873-59	$6,266.70	$305.70	$7,317.00	$5,961

Based upon the information set forth above, MAXIMUS has determined that the Payer has reimbursed the provider $305.70 for code 29879 and $305.70 for code 29873-59. Based upon the New Jersey Administrative Code the Payer should reimburse the Provider an additional $7,011.30 for code 29879 and $5,961.00 for code 29873-59. Therefore, provider should receive an additional total reimbursement of $12,972.30. It is assumed for the purposes of this arbitration that all applicable copayments and deductibles were taken into account when the Payer made its initial payments to the provider.

Pursuant to the New Jersey Health Claims Authorization, Processing and Payment Act (the Act), if it is determined that a payer has withheld or denied payment of the claim in violations of the provision of the Act, the payer shall make payment of the claim of accrued interest of 12% from the date the payer received the provider's claims appeal. In addition, the Payer should make payment to the Provider of record involved in this arbitration.

Evidence Supporting Decision:

The following evidence was relied upon in arriving at the arbitration decision.

1. Centers for Medicare and Medicaid Services - FY 2007 Medicare - Hospital Prospective Payment System (HOPPS) Fee Schedule.

2. Ingenix - Prevailing Healthcare Charge System Jan 2007.

3. Centers for Medicare and Medicaid Services – Addendum DI - Payment Status Indicators for Hospital Outpatient Prospective Payment System.

4. New Jersey Administrative Code §11:21-7.13

5. Payer Evidence of Coverage.

Arbitrators Qualifications:

I am an attorney with over 5 years of health claims processing experience. I have no affiliation with the Payer of New Jersey or the provider or the enrollee involved in this arbitration.

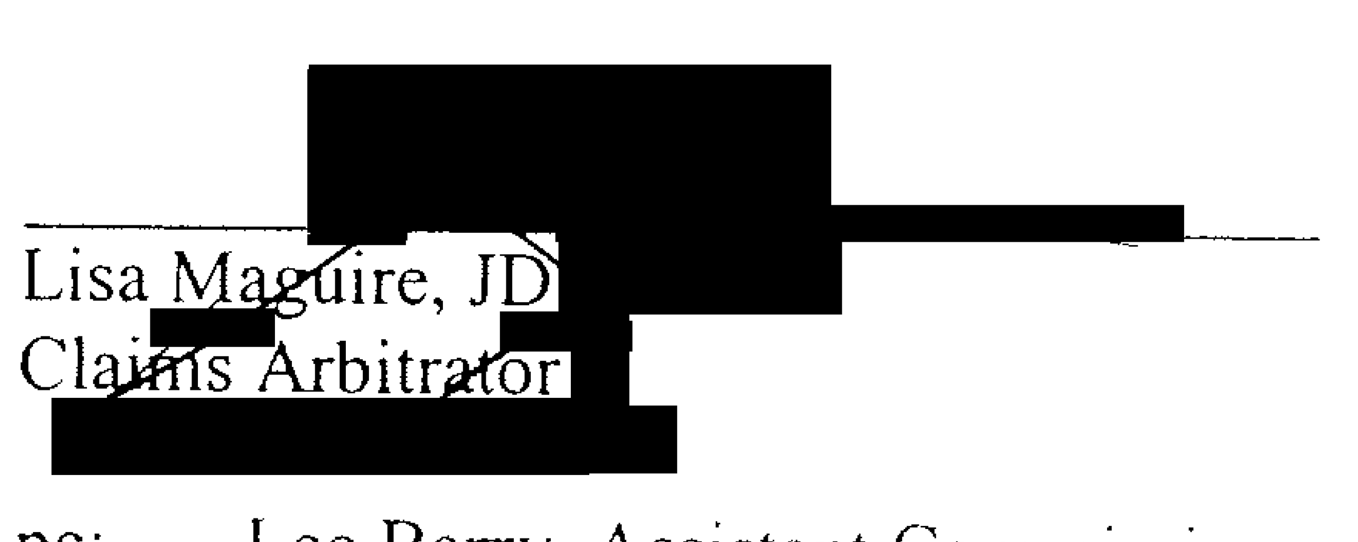
Appeal of MAXIMUS Decision:

This decision is binding. You cannot appeal this decision. The New Jersey Department of Banking and Insurance does not accept appeals of a MAXIMUS decision. Pursuant to the New Jersey Health Claims Authorization, Processing and Payment Act the decision of MAXIMUS is final.

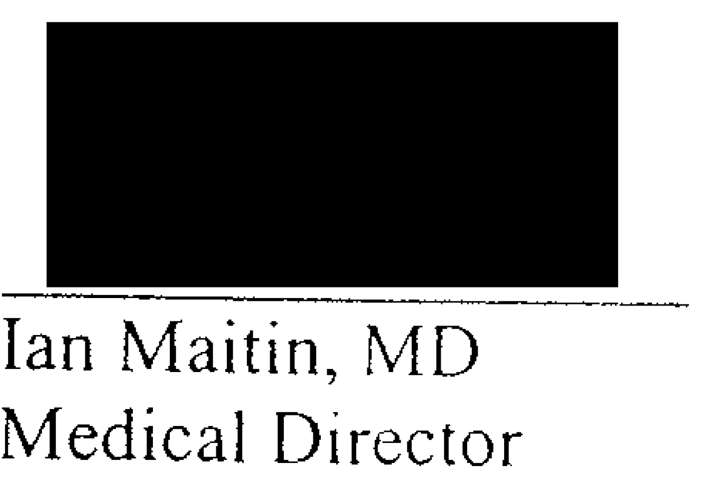
Explanation of MAXIMUS Services:

Please be aware that MAXIMUS is providing an independent arbitration service. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care are the sole responsibility of the patient and that patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

Sincerely,
MAXIMUS, Inc.



Lisa Maguire, JD
Claims Arbitrator



Ian Maitin, MD
Medical Director

pc: Lee Barry, Assistant Commissioner
NJ Dept. of Banking and Insurance