ORDER NO. A12-116

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

IN THE MATTER OF THE REQUEST OF THE	)
NEW JERSEY COALITION FOR QUALITY	)
HEALTHCARE, FOR A STAY OF THE	)
ADOPTION OF AMENDMENTS AND NEW	)
RULES, N.J.A.C. 11:3-4.2, ET SEQ.	)

This matter arises out of a request by the New Jersey Coalition for Quality Healthcare, (hereafter referred to as "the Coalition"), dated November 26, 2012, for a stay of the adoption of new rules, amendments and repeals concerning Personal Injury Protection ("PIP") Benefits, PIP Dispute Resolution, and the PIP Fee Schedules for Physicians, Ambulatory Surgical Centers ("ASCs"), Hospital Outpatient Surgical Facilities ("HOSFs"), Dentists, Durable Medical Equipment, and Ambulance Services as adopted in 44 N.J.R. 2652(c) on November 5, 2012 (hereinafter generally as "the rules"), pending the Coalition's appeal of the adoption of the rules to the Appellate Division of the Superior Court.

The Notice of Adoption of the rules was published in the New Jersey Register on November 5, 2012 and, with the exception of certain amendments that will not become operative until November 5, 2013, will become operative on January 4, 2013. Prior to publishing the Notice of Proposal of the rules, the Department engaged in a lengthy advance notice of rulemaking process pursuant to Executive Order 2 which included the exchange of information and comments with interested parties, including medical providers and insurers. The proposal was published in the New Jersey Register at 43 N.J.R. 1640(a) on August 1, 2011, and more than 18,000 written comments were received. Subsequently, on February 21, 2012, a Notice of

Proposed Substantial Changes Upon Adoption was published in the New Jersey Register at 44 N.J.R. 383(a) pursuant to N.J.S.A. 52:14B-4.10, and more than 100 comments were received on that Notice.

In support of their motion, the Coalition states that the rules are unlawful and invalid as a matter of law in that they exceed the Department's statutory authority because: (1) the rules do not incorporate the 75th percentile of reasonable prevailing fees as mandated by N.J.S.A. 39:6A-4.6(a); (2) the rules' prohibition against certain procedures being performed in an Ambulatory Surgical Center ("ASC") is ultra vires and invalid; (3) the rules impermissibly alter the criteria for the award of attorneys' fees in PIP arbitration proceedings; (4) the definition of "medical necessity" in the rules contravenes the PIP statute and legal precedent; and (5) the rules also contravene the PIP statute and existing case law with respect to the assignment of benefits by insureds to providers. The Coalition asserts that, based upon these purported defects, they have a strong probability of success in their challenge to the legality of the rules. The Coalition also contends that a stay pending appeal would be appropriate to avoid the irreparable harm that would result from implementing the rules, having thousands of New Jersey healthcare practitioners change their procedures and submit claims under the new rules, and then, assuming they are successful, having these practitioners again change procedures and resubmit claims while also requiring insurers to reprocess all claims. They also assert that a failure to stay the rules will increase the cost of providing care for procedures currently performed at ASCs and thereby diminish access to care, and will compromise the quality of and access to care by creating a risk that physicians/ASCs will go out of business or be unwilling to provide certain services to PIP patients due to the low fees provided for such services in the fee schedules. The Coalition further contends that the amendments to the rules on attorney's fees in PIP arbitrations

will encourage insurers to deny coverage and prolong arbitrations, which will result in attorneys declining to accept PIP cases for arbitration and compromise the effectiveness of the PIP dispute resolution program.

Finally, the Coalition avers that a balancing of the equities favors a grant of the stay.

STANDARD OF REVIEW

It is well settled that the Coalition has the burden of establishing that a stay should be granted in this matter by clear and convincing evidence. American Employers' Insurance Co. v. Elf Atochem N.A., Inc., 280 N.J. Super. 601, 611, fn8 (App. Div. 1995); Subcarrier Communications, Inc. v. Day, 299 N.J. Super. 634, 639 (App. Div. 1999) (citing American Employers' Ins. Co., supra). In this application, the Coalition has failed to carry this burden to present clear and convincing evidence to warrant a stay of the rules pending appeal.

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

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

LIKELIHOOD OF SUCCESS ON THE MERITS

First, the Coalition failed to establish that there is a reasonable probability that they will prevail on the merits of their appeal. It is "well-established" that administrative regulations enjoy a presumption of validity. N.J. State League of Municipalities v. Department of Community Affairs, 158 N.J. 211, 222 (1999). The Coalition asserts that the Appellate Division in In re Adoption of N.J.A.C. 11:3-29, 410 N.J. Super. 6 (App. Div.), certif. denied 200 N.J. 506 (2009), impermissibly shifted the burden to the healthcare providers challenging the 2007 PIP rule adoption because it held that the providers in that appeal had failed to present adequate data and documentation to support the challenge to the PIP rules and fee schedules. The Coalition is incorrect. As held therein, it is well-settled in this State that a party challenging a regulation's validity has the burden of overcoming that presumption and demonstrating that the regulation is arbitrary, capricious, or unreasonable. Bergen Pines County Hosp. v. N.J. Dep't of Human Servs., 96 N.J. 456, 477 (1984); In re Adoption of N.J.A.C. 11:3-29, supra, 410 N.J. Super. at 22-24. "A finding that an agency acted in an ultra vires fashion in adopting regulations is generally disfavored. Particularly, in the field of insurance, the expertise and judgment of the

[agency head] may be given great weight." N.J. Coalition of Health Care Professionals, Inc., v. N.J. Dep't of Banking and Ins., Div. of Ins., 323 N.J. Super. 207, 229 (App. Div.), certif. denied, 162 N.J. 485 (1999) (citations omitted). In the context of actions by an administrative agency, "arbitrary and capricious" means "willful and unreasoning action, without consideration and in disregard of circumstances." Bayshore Sewerage Co. v. Department of Envtl. Protection, 122 N.J. Super. 184, 199 (Ch. Div. 1973), aff'd, 131 N.J. Super. 37 (App. Div. 1974), quoted in Worthington v. Fauver, 88 N.J. 183, 204-05 (1982). Action that is "exercised honestly and upon due consideration," is not arbitrary and capricious, even if there is room for another option and "even though it may be believed that an erroneous conclusion has been reached." Bayshore Sewerage Co., supra, 122 N.J. Super. at 199. As discussed in full below, the Coalition has failed to demonstrate any likelihood that they would be able to sustain this burden and prevail in their appeal of the rule adoption.

(A) The Fee Schedules Prescribed by the Rules Meet the Statutory Standard

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

In support of its claim that the newly adopted Physicians' and ASC Fee Schedules do not meet the statutory standard, the Coalition states that the Department was required to gather and apply market-based data to determine the 75th percentile amount for each CPT code.[1] The Coalition asserts that rather than collect this data, the Department relied on imperfect data

[1] To the extent that the Coalition is asserting that the Department should have conducted a survey of physician fees to create the data source for the fee schedule, this notion has already been rejected by the Appellate Division. In re Adoption of N.J.A.C. 11:3-29, supra, 410 N.J. Super. at 31.

sources such as Ingenix, Medicare and the New York Workers' Compensation Fee Schedule to establish the Physicians' Fee Schedule, and upon irrelevant data, such as applying the 300 percent multiplier to the Medicare ASC fee schedule. The Coalition asserts that the statute requires the Department to gather data on what PIP insurers pay and providers receive after appeals and arbitration. The Coalition states that the Department improperly used a Medicare multiplier and then back-checked the results by using a variety of different sources. The Coalition states that the Department has never established how Medicare relates to the 75th percentile of New Jersey market based fees and that, even if the Department could rely on Medicare, it misapplied outdated data from 2007.

Initially, it must be noted that the statutory mandate established by N.J.S.A. 39:6A-4.6(a) to set fees at the reasonable and prevailing fees of 75 percent of practitioners "within the region" has been historically difficult to achieve because there is no single existing database setting forth the reasonable and prevailing fees of 75 percent of all of the medical practitioners in the State. The reality is that, depending upon the payor and the nature of the health insurance policy or health benefits plan under which coverage is provided, physicians and ASCs are paid different amounts for the same service. Nevertheless, the Department in this adoption meets this statutory standard by utilizing the methodology for calculating the fee reimbursement amounts that was affirmed by the Appellate Division in the last PIP appellate challenge and by using updated and new sources of paid fee data, such as FAIR Health. See In re Adoption of N.J.A.C. 11:3-29, supra.

The Coalition fundamentally misunderstands how the Department established the fees for new codes that were added to the Physicians' Fee Schedule in this rulemaking. They assert that the Department had a duty to use market data as to what providers in New Jersey are being paid

to create the Physicians' Fee Schedule. The Department did just that. As discussed in the Summary of the Notice of Proposal, the Department started with the 2011 Medicare Physicians' Fee Schedule ("MPFS") (adjusted to remove the effects of Federal budget neutrality measures) as a base for all fees. The Department used the MPFS as a base for the fee schedule for the first time in the 2007 PIP adoption because the Medicare Resource Based Relative Value System ("RBRVS") is the most comprehensive fee schedule and it calculates physician fees based on Relative Value Units ("RVUs"), which take into account the physician's work, the practice expenses for the procedure and the malpractice premium associated with each CPT code. This use of the MPFS as a base was affirmed by the Appellate Division in In re Adoption of N.J.A.C. 11:3-29, and thus it is appropriate here.

Starting with the 2011 MPFS, the Department recalculated the existing fees on the schedule at the same percentage multipliers, generally 130 percent with upward adjustments for various CPT code families, as was used in the 2007 PIP adoption because those percentages corresponded well to the fees paid by PIP insurers, which are greater than all other healthcare payors. For the approximately 1,100 new CPT codes, the Department initially set the percentage multipliers of MPFS at the same amounts for similar CPT code families. Then, the Department compared all of the fees to paid fee data from New Jersey auto insurers, the New York Workers' Compensation fee schedule, and the FAIR Health allowed (paid) fee module at the 75th percentile for Northern New Jersey that was purchased by the Department.

This very process, including use of MPFS as a base for the Physicians' Fee Schedule, use of multiple paid fee data sources to set the rates, and proofing of the schedule against the auto paid-fee data and general healthcare paid-fee data was explicitly affirmed by the Appellate Division in the appeal of the 2007 PIP Adoption and found to meet the statutory standard in

N.J.S.A. 39:6A-4.6. In re Adoption of N.J.A.C. 11:3-29, supra, 410 N.J. Super. at 36-42. Consequently, the Coalition's assertions that the Department failed to justify its use of Medicare and failed to use New Jersey market data on paid fees are clearly belied by the process.

Furthermore, the Coalition's reliance on the purported expert report by Sean M. Weiss is misplaced. As noted in Order No. A12-114, the Weiss report is inherently flawed. It incorrectly states that the Department used a "blend" of different sources to establish the Physicians' Fee Schedule including Ingenix data and Medicare payment rates based on the 2007 Resource Based Relative Value Scale ("RBRVS"). The report also states that Ingenix is an extremely unreliable source for fee data, citing previous litigation initiated by the New York Attorney General's Office. The report further stated that the Department failed to use a Medicare conversion factor to adjust 2007 Medicare data for use in 2012. The Coalition reasserts all of these allegations in their stay motion before the Commissioner.

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

The Coalition also avers that the Department erred in its use of the FAIR Health database, the successor to Ingenix, in setting the Physicians' Fee Schedule because it is national in scope, based upon billed charges and has no relation to what the 75th percentile of New Jersey providers in a particular region get paid. These assertions are incorrect. As the Coalition appears to understand, the Department only uses paid fee databases in its compilation of the Physicians' Fee Schedule, and such use was affirmed by the Appellate Division twice in Coalition for Quality Health Care, et al. v. Department of Banking and Insurance, 358 N.J. Super. 123 (App. Div. 2003) and In re Adoption of N.J.A.C. 11:3-29, supra. As explained in the proposal and adoption, the Department purchased and used the proprietary FAIR Health allowed (paid) fee database at the 75th percentile for Northern New Jersey as another paid-fee data source against which to check its fee schedule. Therefore, this data was not national in scope, was not based upon "billed" charges, and directly demonstrated the 75th percentile of what New Jersey providers are being paid. Consequently, the Coalition's attacks on the Department's use of the FAIR Health data fail to demonstrate that the fee schedule adoption does not meet the statutory standard or is otherwise unreasonable, arbitrary or capricious.

Furthermore, the Coalition asserts that the new Physicians' Fee Schedule causes a substantial decline in the fees to be paid to providers and that the schedule should be increasing reimbursements by 6-9 percent for inflation alone. The Coalition contends that these failures demonstrate that the schedule fails to incorporate the reasonable and prevailing fees of 75 percent of practitioners as required by N.J.S.A. 39:6A-4.6. These assertions by the Coalition are also incorrect. As noted in the Summary of the Notice of Proposal of the rules, the existing fees on the new Physicians' Fee Schedule increase an average of 7 percent across-the-board – thus satisfying the inflation increase sought by the Coalition, and all of the fees were generally

comparable to, and 85 percent of the fees are greater than, those on the FAIR Health allowed fee database for New Jersey – thus demonstrating that the fee schedule meets, and possibly exceeds, the statutory standard.

In further support of the assertion that the fee schedule does not meet the statutory standard, the Coalition points to nine specific CPT codes for which reimbursement under the new schedule is less than the 2007 fee schedule. Eight of these codes (CPT codes 64479, -80, -83 to -84, -90, -93 to -95) are all pain management procedures. The Department acknowledges that the reimbursements for these pain management CPT codes have been reduced from the 2007 Fee Schedule amounts, but these reductions were not unreasonable. As the Department explained in the Notice of Adoption, Medicare periodically reevaluates the relative value of procedures by taking into account the physician's work, the practice expenses for the procedure, and the malpractice premium associated with each CPT code. In 2008, these changes resulted in the reduction of the Medicare fees for many of the codes in the 60000 series that are used in pain management to reflect updated practice expenses and technology costs. Moreover, the reduction of these fees by Medicare and the Department is supported by the Fair Health paid fee data at the 75th percentile. All of the pain management CPT codes noted as reductions by the Coalition are set at fees higher than the Fair Health allowed fees at the 75th percentile. Similarly, the reimbursement for acupuncture (CPT code 97810), the remaining CPT code noted by the Coalition, has also decreased in this adoption; however, the Department set the reimbursements for stand-alone acupuncture at rates that more than satisfy the statutory standard. As explained in the adoption, the fees for acupuncture were set at the 95th percentile of Fair Health's allowed fee database to satisfy the Department's obligation to set fees at the most current reasonable and prevailing rates. Consequently, the Coalition's arguments regarding these reimbursement

reductions fail because the Fair Health paid fee data used by the Department demonstrates that the reduction of the pain management and acupuncture reimbursements was reasonable and consistent with the statutory standard.

Finally, the Coalition asserts that the Appellate Division's decision in In re Adoption of N.J.A.C. 11:3-29, supra, affirming the Department's methodology for the establishment of the PIP fee schedules is based upon an impermissible and flawed conclusion. The proper forum before which that contention should have been pressed is the New Jersey Supreme Court, and the Department notes that the Court declined to review the Appellate Division's decision in In re Adoption of N.J.A.C. 11:3-29. Moreover, the Appellate Division has sanctioned the very methodology which is now under attack by the Coalition. The Legislature is presumed to be aware of the Appellate Division's 2009 opinion and it has taken no action to amend the statutory provisions at issue. Therefore, the inescapable conclusion is that the Department's methodology is consistent with the Legislative intent underlying N.J.S.A. 39:6A-4.6(a). See, Malone v. Fender, 80 N.J. 129, 137 (1979).

For all these reasons, the Coalition has not demonstrated that it is likely to prevail on the merits of its challenge to the Physicians' Fee Schedule.

B) Restrictions on Procedures in ASCs

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

The Department's rule does not determine where outpatient surgeries can be performed. It simply limits the reimbursement for such procedures by PIP insurers in accordance with its statutory obligation in N.J.S.A. 39:6A-4 to approve a PIP medical benefit plan for "reasonable, necessary and appropriate treatment and provisions of services." The statute goes on to state that, "[M]edical treatments, diagnostic tests, and services provided by the policy shall be rendered in accordance with commonly accepted protocols and professional standards and practices which are commonly accepted as being beneficial for the treatment of covered injury." Pursuant to N.J.S.A. 39:6A-4.6a, the Commissioner also has the exclusive statutory authority to exercise his technical expertise to promulgate schedules of fees in a necessary regulation. As part of its obligation to only provide for the reimbursement of appropriate treatment, the Department determined it was necessary and appropriate to incorporate into the PIP scheme a standard for determining which procedures can be safely performed in an ASC. It has decided to utilize the standards established by one of the nation's largest payors, Medicare, for this determination. The assertion that relatively few adverse events have been reported in ASCs does not meet the statutory standard for deciding which procedures can be performed in these facilities.

N.J.S.A. 39:6A-4.6a provides the Commissioner with broad discretion to select those categories of fees or services which warrant inclusion in the regulation and it does not compel the categories of services or locations in which such services must be available for reimbursement. The Department followed Medicare's determination of which procedures can appropriately be performed in ASCs because Medicare provides a sound and detailed analysis of procedures that can be safely performed in ASCs. Medicare excludes procedures that pose a significant risk to the patient. Procedures are excluded if they: (1) typically require active

medical monitoring and care at midnight following the procedure; (2) are on the inpatient only list; (3) directly involve major blood vessels; (4) require major or prolonged invasion of body cavities; (5) generally result in extensive blood loss; (6) are emergent in nature; (7) are life-threatening in nature; (8) commonly require systemic thrombolytic therapy; or (9) can only be reported using an unlisted surgical procedure. "Medicare Program; Revised Payment System Policies for Services Furnished in Ambulatory Surgical Centers (ASCs) Beginning in CY 2008; Final Rule," Federal Register 72 (August 2, 2007): 42483.

The Coalition argues that this Medicare standard is outdated because it is based on a 5 year-old CMS guideline and because the Medicare population is different. The fact that the Medicare determination guideline was issued five years ago is of no import because it is still in use today and the CMS, which does yearly updates to the Medicare fee schedules, has found no justification to change this determination. The Coalition asserts that these standards were established based upon the experience of the Medicare population, which generally consists of the elderly and the disabled, and that the rules ignore indications that the now-barred procedures have been performed safely in ASCs for years. The assertion that the purported differences in the Medicare population make this standard inappropriate for application to the ASC fee schedule is unpersuasive because the standards are based on the clinical characteristics of the procedures, not upon the age of the patient. In addition, CMS decisions on the procedures that can be performed in an ASC are based on an analysis of patient safety. Consequently, the Department has utilized standards established by one of the nation's largest payors, Medicare, for determining which procedures may be safely performed in an ASC. The fact that relatively few adverse events have been reported in ASCs does not meet the statutory standard for deciding

which procedures can be safely performed in these facilities.[2] Overall, utilization of the Medicare determinations as to the procedures that can be safely performed in an ASC is well within the Commissioner's statutory authority and expertise to determine appropriate treatments, and is reasonable and medically sound.

Finally, the rules as adopted do not usurp the authority of the Department of Health as alleged by the Coalition. The Department's rules and fee schedules only apply to the reimbursement of medical benefits provided under the PIP coverages in private passenger automobile insurance policies, which is well within the express statutory authority granted to the Commissioner in N.J.S.A. 39:6A-4 and -4.6. The limitation on the services that are reimbursable if performed in an ASC is based on patient safety, not on restricting patient choice or on the cost of the procedure. Therefore, it is reasonable and appropriate for the Department to rely upon the expertise and experience of CMS in this regard. Additionally, the Appellate Division has already recognized that the Commissioner has authority under the PIP statutes to impose some limits on an individual's choice in selecting providers and vendors, and the new ASC Facility Fee Schedule falls within this power. Coalition for Quality Health Care v. NJ Dep't of Banking and Ins., 348 N.J. Super. 272, 309 (App. Div. 2002). In sum, the Coalition has failed to demonstrate a likelihood of success on the merits of this issue on appeal.

C) Attorney's Fees in PIP Arbitrations

In further support of the contention that it is likely to prevail on the merits of its appeal, the Coalition asserts that the Department erred by adding a process to N.J.A.C. 11:3-5.6 by which dispute resolution professionals ("DRPs") shall award reasonable attorney's fees for

[2] The Coalition also contends that the rules ban the use of discography in any outpatient facility. This is not correct. The HOSF fee schedule clearly lists the CPT codes for discography (62290 and 62291) with payment indicator N1, which means that the procedures can be performed but are not reimbursable separately because they are packaged with other procedures. The same N1 indicator was inadvertently omitted from the ASC facility fee schedule. The Department will note this error in its Frequently Asked Questions and correct it in a future rulemaking.

successful claimants. Specifically, the Coalition argues that the adopted new rules violate the New Jersey Constitution and exceed the Department's statutory authority because they attempt to regulate the practice of law, which is the exclusive province of the New Jersey Supreme Court. The Coalition also argues that the new rules ignore the need to encourage attorneys to represent PIP claimants. And, it also asserts that PIP cases are contingent which means that the payment of attorneys' fees are not guaranteed, therefore the lodestar analysis as incorporated by the Department errs by not including a process for contingency fee enhancements. The Coalition's arguments do not to demonstrate that they are likely to prevail on the merits of the appeal on this issue.

The adopted rule requiring DRPs to analyze requests for attorney's fees in PIP arbitrations does not unconstitutionally invade the Supreme Court's exclusive regulation of the practice of law. In N.J.S.A. 39:6A-5.1, the Legislature established the PIP arbitration process which specifically provided that the "[C]ommissioner shall promulgate rules and regulations with respect to the conduct of the dispute resolution proceedings." Moreover, N.J.S.A. 39:6A-5.2(g) specifically provides that, "[t]he cost of the proceedings shall be apportioned by the dispute resolution professional. Fees will be determined to be reasonable if they are consonant with the amount of the award, in accordance with a schedule established by the New Jersey Supreme Court." As noted during the rulemaking, the Supreme Court has not established a schedule according to this statute. However, the Supreme Court and the appellate jurisprudence of this State have established a clear process for determining the reasonableness of attorney's fee awards under fee-shifting statutes such as N.J.S.A. 39:6A-5.2(g). Under the Legislature's mandate to adopt rules governing the conduct of the PIP arbitrations, the Department has merely incorporated the courts' own case law into N.J.A.C. 11:3-5.6(e) which requires DRPs to analyze

the reasonableness of attorney's fee awards. The adopted amendments require the DRP to complete and memorialize the courts' attorney fee analysis in the arbitration decision prior to making an award of attorney's fees. Thus, this rulemaking is well within the Department's purview to regulate the conduct of the PIP arbitrations.

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

As noted above, the Department incorporated the jurisprudence of this State that establishes how to determine the reasonableness of attorney fee awards under a fee-shifting statute such as N.J.S.A. 39:6A-5.2(g), which specifically provides that the fees should be consonant with the amount of the arbitration award. See, Rendine v. Pantzer, 141 N.J. 292, 335-

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

The adopted rule incorporates the basic lodestar analysis in the case law that comports with the statutory authority in N.J.S.A. 39:6A-5.2(g) requiring the attorney's fee to be "consonant" with the amount of the PIP arbitration award. The Department believes that contingency fee enhancements in most instances would run counter to this statutory requirement, and therefore the adopted rule does not specifically provide for a contingency fee enhancement analysis as authorized in Rendine, supra, 141 N.J. at 337-341. Additionally, as noted by the Rendine court, any contingency enhancement should consider whether the "likelihood of success is unusually strong" and evaluate whether the risk that counsel would come away empty-handed is remote. Id. at 340-341. To what degree attorneys in PIP arbitrations operate on a contingency fee basis is not known to the Department; moreover, PIP arbitrations are not as procedurally complex or time consuming as traditional litigation, where attorneys who agree to a contingency fee agreement incur substantial expenditures of time, resources, and risk of non-payment. Nevertheless, nothing in the rule prohibits counsel from requesting such contingency fee enhancements in PIP arbitration awards and, if requested, DRPs would have to analyze whether an upward adjustment of the lodestar is appropriate and "consistent with the jurisprudence of this State," as espoused in Rendine. See N.J.A.C. 11:3-5.6(e).

The Coalition also asserts that PIP carriers are concerned by attorneys' fees that exceed the cost of PIP arbitration awards and that uncertainty regarding the size of attorney fee awards discourages inappropriate denials by insurers. At page 10 of its brief, the Coalition states "Attorneys' fees can have a deterrent effect on insurance companies' inappropriate reimbursement practices; however, the proposed regulations eliminate much of that effect." The Department does not believe that the attorney fee award provision in N.J.S.A. 39:6A-5.2(g) was intended by the Legislature to function as a deterrent to insurance companies acting improperly in their reimbursement practices; rather, such fee-shifting statutes are intended to encourage attorney representation when the amounts in controversy are limited. The fact is that N.J.S.A. 39:6A-5.2(g) contains an express limitation on the amount of attorneys' fee awards in PIP arbitrations, namely the fee must be consonant with the award. The statute contains no text that can in any way be construed as indicating that attorney fees are to be set based on an attenuated and hypothetical deterrent effect they may or may not have on inappropriate general conduct by insurers.

Furthermore, the fact that N.J.S.A. 39:6A-5.2(g) specifically directs establishment of an attorney fee schedule for the awarding of fees in PIP arbitrations also belies the Coalition's assertions that certainty in attorney fee awards will harm patients because insurers will seek to initially deny treatments and delay reimbursement. Overall, the Department believes that the amendments in this PIP adoption and the expanded new fee schedules will ameliorate to a large extent the need for arbitrations because of increased cost certainty and less UCR reimbursements and, therefore, any perceived need in the provider community to deter insurer delays/denials in reimbursement will be similarly reduced.

In light of the above, the Coalition has failed to demonstrate a reasonable probability of success on the merits of this issue on appeal.

D) Medical Necessity Standard

The Coalition asserts that the new rules contravene the PIP statute by improperly narrowing and redefining the statutory definition of medical necessity in N.J.S.A. 39:6A-4. The Coalition states that, "the proposed standard for 'medical necessity' under the Rules, which is not a national standard, is at odds with the statutory definition contained in the PIP statute itself." These assertions also fail to demonstrate a reasonable probability of success on the merits because, as noted in the adoption, the Department is acting well within its statutory authority to define the term "standard professional treatment protocols."

The Department is not redefining "medical necessity." The definition of "medically necessary or medical necessity," which has been in N.J.A.C. 11:3-4.2 for many years, contains the phrase, "standard professional treatment protocols." The Department is simply defining that term. The definition of "standard professional treatment protocols" is not inconsistent with the definition of "medical necessity" in N.J.S.A. 39:6A-4(a), and is not, as the Coalition also contends, inconsistent with Thermographic Diagnostics, Inc. v. Allstate Ins. Co., 125 N.J. 491, (1991).

The definition of "medically necessity" in N.J.S.A. 39:6A-4(a) reads in part,

> Medical treatments, diagnostic tests, and services provided by the policy shall be rendered in accordance with commonly accepted protocols and professional standards and practices which are commonly accepted as being beneficial for the treatment of the covered injury. Protocols and professional standards and practices and lists of valid diagnostic tests which are deemed to be commonly accepted pursuant to this section shall be those recognized by national standard setting organization, national or state professional organizations of the same discipline as the treating provider, or those designated or approved by the

> [C]ommissioner in consultation with the professional licensing boards . . .

This language was added to the statute by AICRA in 1998 after the Thermographic Diagnostics decision referenced above was issued in 1991. "[T]he Legislature is presumed to be aware of judicial construction of its enactments," and the Thermographic Diagnostics methodology of determining medical necessity was under a prior version of N.J.S.A. 39:6A-4, which did not contain the above language. DiProspero v. Penn, 183 N.J. 477, 494 (2005) (citations omitted). However, even the court in Thermographic Diagnostics recognized that, "[t]he use of the treatment, procedure, or service must be warranted by the circumstances and its medical value must be verified by credible and reliable evidence." Thermographic Diagnostics, supra, 125 N.J. at 512.

The Legislature's subsequent AICRA amendment provides a basic methodology on how to determine that the medical value of the treatment is verified by credible and reliable evidence by defining what constitutes standard professional treatment protocols under PIP. This post-Thermographic Diagnostics amendment to the statute specifically provides for the Commissioner to make policy determinations as to what treatment is reasonable, appropriate and necessary, and the new definition of standard professional treatment protocols in this adoption is well within the this statutory authority. For these reasons, the Department does not believe that the medical necessity standard set forth in Thermographic Diagnostics has any relevance to the adopted rule amendment, and the Coalition has failed to demonstrate a likelihood that they will prevail on this issue on appeal.

E) Assignments of Benefits and Duties

The Coalition asserts that the Department has contravened the PIP statute by permitting the assignment of duties and benefits in N.J.A.C. 11:3-4.9 when N.J.S.A. 39:6A-4 only mentions the assignments of benefits to providers under the policy.

The Coalition also asserts that the amendment to N.J.A.C. 11:3-4.9 attempts to subvert the Appellate Division's decision in Selective Ins. Co. of America v. Hudson East Pain Management Osteopathic Medicine and Physical Therapy, 416 N.J. Super. 418 (2010), aff'd on other grounds 210 N.J. 597 (2012), by permitting the insurers carte blanche to "unilaterally impose duties, including those to 'cooperate' by providing full-scale discovery and Examinations Under Oath." The Coalition fails to note that the Supreme Court did not adopt the reasoning of the Appellate Division in this matter, and fails to recognize that neither decision precluded the assignment of duties under the policy to a provider of service benefits. As noted by the Supreme Court on certification, the Appellate Division relied upon the legally significant distinction between an assignment, which conveys benefits or the potential to receive benefits, and a delegation, which conveys duties or obligations. Selective, supra, 416 N.J. Super. at 426 (citing 9 Corbin on Contracts §§ 47.1, 47.6 (John E. Murray, Jr. ed. 2007)). Based upon this distinction, the Appellate Division held that a general assignment of benefits in the PIP context and the specific assignment at issue in the matter at bar did not function to impose the duty to cooperate under the policy unless the assignee providers expressly assent to assume the duty or were a party to the original agreement. Ibid.

In July 2012, the Supreme Court issued its decision in the case, in which it declined to express its views on this issue. In so doing, the Court pointed to the Restatement (Second) of Contracts (1979), which recognized that "[t]he principle that an assignment of benefits does not carry with it the corresponding duties of the assignor is not universal in its application[,]" and

noted that the Legislature has incorporated such assumptions of duties in other statutory assignment of benefits (see N.J.S.A. 12A:2-210(4)). Selective Insurance v Hudson East, supra, 210 N.J. at 606-607. The Supreme Court ultimately held that the duties of the assignee can be no greater than those of the assignor, and because the insured under the policy could not be compelled to provide the type of information sought by the insurer, then neither could the provider under the "duty to cooperate" clause. Id. at 607. Furthermore, the Court held that in PIP arbitrations, N.J.S.A. 39:6A-13(g) limits the exchange of discovery to information concerning a patient's "history, condition, treatment, dates and cost of such treatment" and the scope of this cannot be expanded. Id. at 608. The Department's rule does not seek to subvert or extend either decision.

The purpose of the amendment to N.J.A.C. 11:3-4.9 is to clarify the issue of whether duties under an auto insurance policy are assignable to providers generally, and to permit an insurer to require that a provider accept the duty to cooperate if assigned by the insured. In the adoption, it was noted that certain providers have refused to respond to reasonable information requests by insurers in connection with the investigations of claims and that this clarification regarding the permissible assignment of both benefits and duties will enable insurers to require the provision of information during those investigations as long as legally permissible. As noted in the adoption, many carriers already include a requirement that providers submit to EUOs in their restrictions on the assignment of PIP benefits, and EUOs are one of the most common duties of an insured in an investigation of a claim. Therefore, requiring providers to submit to EUOs in the investigation of a PIP claim does not extend their duties beyond those of the insured in violation of the Selective decision. Moreover, nothing in the rule expands the scope of discovery in PIP arbitrations beyond the statutory limits of N.J.S.A. 39:6A-13(g). In fact, the

Department by adopting this provision seeks to prevent a significant number of arbitrations by enabling insurers to get the information needed to investigate and pay claims. Furthermore, the Department intends to monitor its implementation and the specific duties sought for assignment to providers in the insurers' policy forms. The Department believes that this rule is necessary to eliminate confusion and is well-within its statutory authority to "implement any procedure or practice ... to prevent fraudulent practices by the insured, insurers, providers of services or equipment . . ." under N.J.S.A. 17:33B-42. In light of the above, the Coalition has failed to demonstration a likelihood of prevailing on the merits of this issue on appeal.

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

PUBLIC INTEREST

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

In enacting N.J.S.A. 39:6A-4.6(a), the Legislature required the Commissioner to develop fee schedules that reflect the prevailing fees for services in connection with PIP coverage. In Coalition for Quality Health Care, 358 N.J. Super. 123 (App. Div. 2003), the Appellate Division directed the Department to consider promulgating a more comprehensive Physicians' Fee Schedule than that in the former rules. The court did so because the inclusion of more CPT

codes in the PIP fee schedules will increase costs certainty and enable insurers and providers to streamline their respective claims payment and submission systems, thereby reducing the administrative component of their total costs and fostering reductions in the cost of PIP coverage. For this reason and because these rules implement the public policy of this State as expressed by the Legislature and interpreted by the courts, the adoption of the new and amended rules is plainly in the public interest.

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

For all of these reasons, the public interest favors permitting the new and amended PIP rules and fee schedules to take effect. Finally, I also note that the Coalition's submission made

no mention of this prong of the four-part test for the ordering of temporary restraints. Consequently, it cannot be concluded that they have carried their burden of establishing that the public interest favors a stay.

BENEFITS VS. HARM OF GRANTING THE APPLICATION

On balance, the benefits of granting the stay will not outweigh the harm such relief will cause other interested parties. The Coalition has provided no facts on which it may be concluded that the balance of the equities favors them. In contrast, permitting the implementation of these new and amended rules and fee schedules will benefit the vast majority of providers and New Jersey auto insurance policyholders. The rules effectuate substantial increases in the fees for most of the codes listed in the current Physicians', dental, and durable medical equipment fee schedules. Further delaying the date on which these changes will become operative will adversely affect providers who perform the procedures and render the services to which these codes correspond.

In addition, the challenged adoption is the culmination of the Department's most recent efforts to fulfill the statutory mandate to establish a comprehensive fee schedule and update that fee schedules for inflation every two years. The rules implement the beneficial public policies that the application of current and comprehensive PIP fee schedules were intended to serve, including the dampening effect such schedules have on the administrative costs of providing PIP coverage and medical care to auto accident victims. The adopted amendments also add a significant number of codes to the fee schedules. The adoption of this more comprehensive Physicians' Fee Schedule and of the amendments that address the fees that may be charged by ASCs will reduce the upward pressure on rates currently caused by the frequency of disputes and expensive arbitrations. And, in sum, these amendments will foster a maximization of PIP

benefits for all auto insureds. Thus, the balance of equities does not support granting the requested relief.

IRREPARABLE HARM

Irreparable harm will not result to the Coalition, their providers, or their patients if the stay is denied. The Coalition asserts that a failure to stay the rules will severely and negatively impact patients in New Jersey and their treating healthcare providers because procedures cannot be performed in ASCs. They allege this will affect cost and access to quality healthcare services. Other than the higher facility fees under the HOSF schedule, the Coalition has not provided any factual support for these assertions. Patients will not be harmed and can receive needed treatment at a hospital or HOSF. In fact, the Department believes that these rules will prevent irreparable harm to patients by ensuring that the only procedures performed in an ASC are those which can be done safely. The Coalition has supplied no facts in support of its assertion of possible access to care crises, and it has merely listed a speculative parade of horribles that will result from the rules becoming operative. Indeed, during each adoption of PIP rule amendments, one or more parties have made this argument; however, each PIP adoption and the new fee schedules associated therewith have eventually become operative with little to no revision after appel ate review, and yet, no treatment crisis has ever occurred.

Secondly, the Coalition asserts that the "substantially lower fees" in the new fee schedules will drive physicians and ASCs out of business. This argument is disproven by the facts. The physician reimbursements are going up an average of 7 percent across-the-board under the new schedule, and 85 percent of the fees are higher than the FAIR Health paid fee data at the 75th percentile. Furthermore, as discussed above, all of the reductions in fees complained of by the Coalition are supported by the FAIR Health paid fee data which demonstrates that the

reductions were necessary to comply with the statutory standard in N.J.S.A. 39:6A-4.6. By primarily basing the levels of fees in the revised Physicians' Fee Schedule upon paid fee data supplied by FAIR Health at the 75th percentile and data reflecting claim payments actually made by auto insurers, and by utilizing the methodology affirmed by the Appellate Division in In re Adoption, supra, the Department has ensured that the payment levels in the new schedule are not inappropriately low, but instead meet the statutory standard of approximating the reasonable and prevailing fees at the 75th percentile on a regional basis.

Moreover, as discussed above, the Coalition's assertions that the attorney fee analysis in PIP arbitrations will encourage insurers to delay or deny reimbursements to the detriment of patients is also specious. To the contrary, the Department believes that this PIP adoption as a whole, including the attorney fee provisions and especially the expanded new fee schedules, will result in a large reduction of PIP arbitrations because of the increased cost certainty provided in the rules and the elimination of usual, customary and reasonable reimbursements for approximately 1,100 more CPT codes. Thus, the Coalition's arguments of irreparable harm in this regard also fail.

The Coalition also asserts that the harm that would be caused by thousands of claims being submitted, arbitrated, and/or paid pursuant to the new fee schedules will be virtually impossible to undo if the rules are overturned on appeal. This assertion is contradicted by the facts and the case law. In reality, providers will merely need to change the amounts of their currently billed fees to the maximum amounts established in the amended schedules for services rendered on or after January 4, 2013. In addition, the process of providers generating and submitting bills to insurers for reimbursement takes time. The lag between rendering the service and billing for that service will allow providers adequate time to adjust to the new fee amounts.

Moreover, if bills are submitted by providers at rates other than the amounts specified in the schedules, the impact of such will be null because insurers will adjust payment amounts to comply with the fee levels prescribed in the schedules. Finally, it is inevitable that both providers and insurers will be processing bills under both fee structures until the bills for all services rendered prior to the operative date of the rules have been submitted and paid. Such a period of operating under dual claims systems will be required regardless of the amounts included in the amended fee schedules. Furthermore, the courts have consistently held that the loss of income or pecuniary harm does not constitute irreparable harm for purposes of obtaining a stay, and thus the claims of monetary losses by providers and ASCs does not rise to the level of irreparable harm. Bd. of Ed. of Union Beach v. N.J. Ed. Ass'n, et al, 96 N.J. Super. 371, 391 (Ch. Div. 1967), aff'd 53 N.J. 29 (1968).

Finally, as I stated in Order No. A12-114, it is incumbent upon me to note that truly irreparable harm could result from a stay of these rules. These rules provide necessary, but reasonable, reimbursement increases for all PIP providers of medical and dental treatments, transportation, therapy, and DMEs, which were delayed by the litigation of the 2007 PIP amendments and the lengthy stay of implementation of those rules for almost two years. They also strike an appropriate balance by including more than 1,100 new CPT codes in the schedule to ensure cost certainty which will result in fewer arbitrations over UCR, a reduction in fraudulent activity, and the containment of PIP premium costs for all New Jersey auto insureds. A lengthy delay of the implementation of these rules will be costly across the board, and in particular to New Jersey policyholders and providers who are not affiliated with the Coalition. This is an added consideration as to why this stay request must be denied.

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

CONCLUSION

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

IT IS SO ORDERED this 21st day of December, 2012.

Kenneth E. Kobylowski
Acting Commissioner