

All PIP Rule Changes – combining the original proposal, the notice of substantial changes upon adoption and the notice of adoption- new text is bold, **thus**, deletions are bracketed, [thus]

SUBCHAPTER 4. PERSONAL INJURY PROTECTION BENEFITS; MEDICAL PROTOCOLS; DIAGNOSTIC TESTS

11:3-4.2 Definitions

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

...

“Days” means calendar days unless specifically designated as business days.

1. A calendar and business day both end at the time of the close of business hours. Insurers shall set a close of business time in their Decision Point Review plans;

2. In computing any period of time designated as either calendar or business days, the day from which the designated period of time begins to run shall not be included. The last day of a period of time designated as calendar days is to be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday or legal holiday.

3. Example: Decisions on treatment appeals shall be communicated to the provider no later than 10 days from the date the insurer acknowledges receipt to the provider. The insurer acknowledges receipt by facsimile transmission dated 3:00 P.M. on Wednesday, June 8. Day one of the 10-day period is Thursday, June 9. Since the 10th day would be Saturday, June 18, the insurer’s decision is due no later than Monday, June 20.

...

“PIP vendor” means a company used by an insurer [to administer its decision point review plan] for utilization management.

...

“Standard professional treatment protocols” means evidence-based clinical guidelines/practice/treatment published in peer-reviewed journals.

“Utilization management” means a system for administering some or all of an insurer’s decision point review plan, including, but not limited to, receiving and responding to decision point review and precertification requests, making determinations of medical necessity, scheduling and performing independent medical examinations (IMEs), bill review and handling of provider appeals.

[“WCMCO” means a workers’ compensation managed care organization approved pursuant to N.J.A.C. 11:6.]

11:3-4.4 Deductibles and co-pays

(a) - (c) (No change.)

(d) An insurer may file policy language that waives the co-payment and deductible in (a) and (b) above when the insured receives medical treatment from a provider that is part of an ODS or [a WCMCO network] that has contracted with the insurer or its PIP vendor. The insured shall not be required to elect to use the providers or facilities in such an ODS [or a WCMCO network] either at issuance of the policy or when the claim is made.

1. Upon receipt of notification of a claim, the insurer or its PIP vendor shall make available to the insured information about physicians and facilities in any ODS [or WCMCO network] with which it has a contract.

i. The information shall include a notice that the insured is not required to use the providers or facilities of an ODS [or a WCMCO network] with which the insurer or its PIP vendor has contracted and indicate that if the insured chooses to receive covered services from such providers or facilities, the deductible and copayments in (a) and (b) above would not apply.

ii. The information shall also indicate that the insured may seek treatment from providers and facilities that are not part of an ODS [or WCMCO network] with which the insurer or its PIP vendor has contracted, in which case the deductible and copayments in (a) and (b) above would apply.

2. The actual ODS [or WCMCO network] access fee or 25 percent of the reduction in charges resulting from the use of the ODS [or WCMCO network] provider, whichever is less, may be included within the policy limits for any single bill from an in-network provider in the ODS [or WCMCO network] with billed charges of \$10,000 or more.

Example: A \$10,000 charge is reduced by the ODS [or WCMCO network] contract with the insurer by [40] **45** percent to \$5,500. The insurer could include the ODS [or WCMCO network] access fee or \$1,125 (25 percent of the \$4,500 reduction), whichever is less, within the policy limits.

(e) - (i) (No change.)

11:3-4.7 Decision point review plans

(a) – (b) (No change.)

(c) A decision point review plan filing shall include the following information:

1. Identification of any PIP vendor with which the insurer has contracted **and a copy of the contract between the insurer and the PIP vendor. No insurer shall contract with a PIP vendor unless the vendor is registered with the Department pursuant to N.J.A.C. 11:3-4.7A;** [PIP vendors shall designate a New Jersey licensed physician to serve as medical director for services provided to covered persons in New Jersey. The medical director shall ensure that decision point review and precertification requests are based upon medical necessity in accordance with the requirements of this subchapter;]

2. – 5. (No change.)

6. An internal appeals procedure that [permits the provider to provide additional information and have a rapid review of a decision to modify or deny reimbursement for a treatment or the administration of a test] **meets the requirements of N.J.A.C. 11:3-4.7B;**

7. Reasonable restrictions on the assignment of benefits pursuant to N.J.A.C. 11:3-4.9(a); [and]

8. Reasonable restrictions on what types of providers may submit decision point review requests; and

[8.] **9.** (No change in text.)

(d) The informational materials for policyholders, injured persons and providers shall be on forms approved by the Commissioner and shall include at a minimum the information in (d)1 through 9 below. In order to make the requirements of this subchapter easier for insureds and

providers to use, the Commissioner may by Order require the use of uniform forms, layouts and language of information materials.

1. How to contact the insurer or vendor to submit decision point review/precertification requests including the telephone, facsimile numbers, [or] e-mail addresses **or through a website**. The insurer or its vendor shall be available, at a minimum, during normal working hours to respond to decision point review/precertification requests;

2.- 9. (No change.)

(e) – (g) (No change.)

11:3-4.7A PIP vendor registration requirements

(a) **No company shall perform utilization management services for an insurer unless registered as a PIP vendor pursuant to this section.**

(b) **Any PIP vendor working for an insurer prior to the effective date of this rule shall file for registration by February 3, 2013.**

(c) **Application for registration shall be made on a form prescribed by the Commissioner, which can be found on the Department's website at <http://www.state.nj.us/dobi/pipinfo/aicrapg.htm>.**

(d) **The application shall be accompanied by the applicant's business plan, which shall include the following information:**

1. **A statement generally describing the applicant, its facilities, personnel, and the services to be offered by the PIP vendor;**

2. **The name of its medical director(s) licensed to practice as physician(s) in New Jersey and a detailed explanation about how the medical director(s) provide(s) oversight of determinations of medical necessity;**

3. The name and contact information of a person at the vendor who is designated to receive and handle complaints and inquiries from the Department;

4. Information on activities undertaken or to be undertaken in New Jersey by the company;

5. A demonstration of the applicant's capability to provide a sufficient number of experienced and qualified personnel in the areas of PIP utilization management, and information on staffing levels, including, but not limited to, training, hiring requirements, experience of staff in general and with PIP utilization management in particular;

6. A statement about whether the applicant is licensed or certified as an entity that has networks as that term is defined in N.J.A.C. 11:3-4.8(a) or accredited by nationally recognized accrediting agencies such as URAC (<http://www.urac.org/>) in Health Utilization Management; and

7. A copy of the applicant's certificate of incorporation.

(e) The application shall also be accompanied by the following information concerning how the applicant will handle PIP utilization management:

1. The vendor's clinical review criteria and protocols. The information shall include a descriptive flow chart of its processes used in decision-making, which shall be based on written clinical criteria and protocols developed with involvement from practicing physicians and other licensed health care providers, and be based upon generally accepted medical standards and standard professional treatment protocols;

2. A copy of the vendor's policies and procedures that demonstrate that the vendor is handling utilization management in accordance with N.J.A.C. 11:3-4, 5 and 29; and

3. The mechanisms it uses to detect underutilization and overutilization of services.

(f) A PIP vendor that arranges the physical examinations of injured parties pursuant to N.J.A.C. 11:3-4.7(e) shall submit the criteria it uses to select providers to be on the vendor's panel of examining providers, how it evaluates the quality of an examining provider's examination report and how it avoids conflicts of interest when examinations are ordered and scheduled.

(g) Two copies of the information in (a) through (f) above shall be submitted to the Department at the following address:

New Jersey Department of Banking and Insurance

Office of Property and Casualty

P.O. Box 325

Trenton, NJ 08625-0325

(h) The Department shall advise the applicant if the application is incomplete not later than 60 days after receipt of the application. Notice to the applicant that the application is incomplete shall specify the missing items or information. The Department shall disapprove an incomplete application if the requested information is not provided within 30 days of the notification to the applicant. If the Department does not notify the applicant of missing items or information within 60 days of receipt, the application shall be deemed complete.

(i) The Commissioner shall approve an application for registration if he or she finds that the applicant has demonstrated the ability to perform services in a manner that meets the requirements of this subchapter.

(j) The Commissioner may deny an application for registration as a PIP vendor if he or she finds that any of standards established by this subchapter have not been met or for any other reasonable grounds.

1. If the application for registration is denied, the Commissioner shall notify the applicant in writing of the reasons for the denial.

2. When the Department denies an application for registration, the applicant may request a hearing within 30 days of receipt of the denial by submitting a request in writing to the address in (g) above setting forth, with specificity, the reasons that the applicant disputes the Department's denial notice.

(k) Registration shall be effective for a period of two years. Registered PIP vendors shall reapply for registration 90 days prior to expiration by submitting the information in (d) through (f) above showing changes to the items previously submitted.

(l) All data or information in the PIP vendor's application for registration and the vendor's contract with the insurer required to be submitted pursuant to N.J.S.A. 11:3-4.7(c)1 above shall be confidential and shall not be disclosed to the public, except as follows:

1. The PIP vendor's certificate of incorporation;

2. The PIP vendor's address;

3. The names of the PIP vendor's officers and directors, or the individuals in the organization responsible for the administration of utilization management including the medical director(s); and

4. The date of registration of the PIP vendor and date that registration expires.

(m) The Commissioner may suspend or revoke the registration of a PIP vendor upon finding that the PIP vendor no longer meets the standards set forth in this subchapter; that PIP utilization review services are not being provided in accordance with the requirements of this subchapter; or that the registration was granted based on false or misleading information.

1. Proceedings to revoke or suspend the registration shall be conducted pursuant to N.J.A.C. 11:17D.

2. Upon request of the PIP vendor for a hearing, the matter shall be transferred to the Office of Administrative Law for a hearing conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

11:3-4.7B Internal appeals procedure

(a) The internal appeals process shall permit a provider who has been assigned benefits pursuant to N.J.A.C. 11:3-4.9 or has a power of attorney from the insured to submit additional information and have a rapid review of an adverse decision by the insurer.

(b) An adverse decision is any determination by the insurer with which the provider does not agree and includes, but is not limited to:

1. Determinations of medical necessity for treatment or testing requested by the provider via a properly completed Decision Point Review/Precertification Request;

2. Disputes about whether the insured's injuries were caused by a motor vehicle accident;

3. Disputes between the insurer and the provider concerning the time of notification, receipt, and submission of Decision Point Review/Precertification requests or other notifications required by N.J.A.C. 11:3-4;

4. Disputes about the imposition of the deductibles and copayments in N.J.A.C. 11:3-4.4;

5. A provider's claim that a payment from the insurer is overdue pursuant to N.J.S.A. 39:6A-5g;

6. Disputes involving a provider's usual, customary and reasonable fee; or

7. Disputes about coding, including, but not limited to: which HCPCS, CPT or CDT code properly represents the service performed, sometimes known as downcoding; the use of unlisted codes; and the application of the NCCI edits.

(c) There are two types of internal appeals:

1. Treatment appeals about the medical necessity of future treatment or testing that was requested by the provider on a properly completed Decision Point Review/Precertification Request; and

2. Administrative appeals for all other types of adverse decisions.

(d) All appeals shall be filed using the form established by the Department by Order in accordance with N.J.A.C. 11:3-4.7(d). The appeal form and any supporting documentation shall be submitted by the provider to the address or fax number designated for appeals in the insurer's DPR plan.

1. The insurer's DPR plan shall include a regular mailing address and a fax number for filing appeals. The insurer may also establish a procedure in its DPR plan for the submission and acknowledgment of appeals by electronic means.

2. The appeal form from the provider must reference the correct insurance claim number, date of loss and patient name, clearly identify the adverse decision that is the basis for the appeal and must have been sent to the address or fax number designated for appeals in the insurer's DPR plan.

3. For appeals, acknowledgments and decisions sent by regular mail, it shall be the responsibility of the sender to provide proof that the item was mailed.

4. A confirmation generated by a fax machine or computer that shows the time, date, and fax number of the sending and receiving machine shall be evidence that the appeal, acknowledgment or decision was faxed and received. The insurer must accept fax confirmations.

5. For appeals, acknowledgments and decisions sent by regular mail, the postmark date shall be considered as the date the appeal, decision or acknowledgment was mailed.

(e) A treatment appeal shall be submitted no later than five business days after the provider has received notice of the adverse decision that is the basis for the appeal.

1. Treatment appeals that are not submitted in accordance with the time frame in (e) above may not be submitted as administrative appeals. If a provider misses the deadline to submit a treatment appeal, he or she may submit another decision point review request for the treatment or testing in accordance with the insurer's DPR plan.

(f) Nothing in this section shall be construed so as to require reimbursement of tests or treatments that are not medically necessary or to prevent the application of the penalty co-payments in N.J.A.C. 11:3-4.4(e).

(g) An administrative appeal shall be submitted within 180 days of the adverse decision that is the basis for the appeal.

(h) The insurer shall acknowledge receipt of the appeal by regular mail, fax or electronic means on a form established by the Department by Order pursuant to N.J.A.C. 11:3-4.7(d).

1. The receipt of treatment appeals shall be acknowledged within three business days.

2. The receipt of administrative appeals shall be acknowledged within five business days.

3. Appeals received without the information required by (d)2 above shall be acknowledged in the time frames set forth above as “Incomplete” and with the missing or incorrect information noted. Appeals received after the deadlines in (e) and (g) above shall be acknowledged as “Late Appeals.” An incomplete filing or late appeal does not constitute an appeal pursuant to this subchapter.

(i) The insurer shall conduct a review of the appeal and notify the provider of its decision by fax, mail or electronic means. The insurer may contact the provider by telephone but must follow up with a written decision that is transmitted as described (h) above.

1. Decisions on treatment appeals shall be received by the provider who submitted the appeal no later than 10 days from the date the provider receives the acknowledgment of the appeal.

2. Decisions on administrative appeals shall be received by the provider who submitted the appeal no later than 30 days from the date the provider receives the acknowledgment of the appeal.

3. An insurer may determine that a physical examination pursuant to N.J.A.C. 11:3-4.7(e) is necessary to respond to the appeal. In that case the time periods in (i)1 and 2 above shall start after the examination has been conducted and the report received.

(j) Pursuant to N.J.A.C. 11:3-5.6(a)2, a provider acting on assignment or the holder of a power of attorney from the insured must have filed an internal appeal prior to filing for alternate dispute resolution pursuant to N.J.A.C. 11:3-5. The demand for arbitration must be accompanied by the internal appeal decision or proof that the appeal was filed. The rules of the dispute resolution administrator shall set forth how such proof shall be submitted.

1. The rules of the dispute resolution administrator shall include penalties for providers and their attorneys who make arbitration demands without having exhausted the internal appeals process.

(k) An insurer that fails to respond to an internal appeal filed in accordance with (a) through (i) above shall lose the right to raise defenses in an arbitration on the issue that was the subject of the appeal. However, the insurer can raise other valid and relevant defenses in the arbitration. Example: A provider makes a decision point review request for treatment, which is denied by the insurer as not being medically necessary. The

provider appeals the decision in accordance with the procedures in this subchapter. The insurer fails to respond to the appeal and the provider makes a demand for arbitration. By failing to respond to the appeal, the insurer loses the right to argue that the treatment requested in the Decision Point Review was not medically necessary. However, the insurer is not precluded from raising other defenses at the arbitration proceeding.

11:3-4.8 Voluntary networks

(a) (No change.)

(b) Voluntary networks may be offered for the provision of the following types of non-emergency benefits only:

1. – 2. (No change.)

3. The electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b)1 through 3 except for needle EMGs, **H-reflex and nerve conduction velocity (NCV) tests** performed **together** by the treating physician;

4. – 6. (No change.)

(c) – (e) (No change.)

11:3-4.9 Assignment of benefits; public information

(a) **Pursuant to N.J.S.A. 39:6A-4, an insured may only assign benefits and duties under the policy to a provider of [medical expense] service benefits.** Insurers may file for approval policy forms that include reasonable procedures for restrictions on the assignment of personal injury protection benefits **and duties under the policy**, consistent with the efficient administration of the coverage **and the prevention of fraud.** Insurers may not prohibit the assignment of benefits to providers. Reasonable restrictions may include, but are not limited to:

1. A requirement that as a condition of assignment, the provider agrees to follow the requirements of the insurer’s decision point review plan for making decision point review and precertification requests; **and/or**

2. A requirement that as a condition of assignment, the provider shall hold the insured harmless for penalty co-payments imposed by the insurer based on the provider’s failure to follow the requirements of the insurer’s Decision Point Review Plan[; and/or].

[3. A requirement that as a condition of assignment, the provider agrees to submit disputes to alternate dispute resolution pursuant to N.J.A.C. 11:3-5.]

(b) Insurers shall file policy language requiring that providers who are assigned benefits by the insured or have a power of attorney from the insured make an internal appeal pursuant to N.J.A.C. 11:3-4.7B prior to making a request for dispute resolution in accordance with N.J.A.C. 11:3-5.

[(b)] (c) (No change in text.)

SUBCHAPTER 5. PERSONAL INJURY PROTECTION DISPUTE RESOLUTION

11:3-5.2 Definitions

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

...

“In-person proceeding” or “in-person case” means a PIP dispute where the parties or their representatives appear in person or telephonically before the DRP to present their cases in accordance with the rules of the dispute resolution organization.

...

“On-the-papers proceeding” or “on-the-papers case” means a PIP dispute where the parties or their representatives submit written documentation supporting their case and the DRP decides the case based solely upon the documentation without any in person or telephonic appearances by the parties or their representatives in accordance with the rules of the dispute resolution organization. On-the-papers proceedings are only permitted where all parties consent or where there is no further treatment at issue and the amount at issue in the dispute is less than \$1,000.

...

11:3-5.4 Dispute resolution organizations

(a) (No change.)

(b) The dispute resolution organization shall develop and maintain a dispute resolution plan approved by the Commissioner that sets forth its procedures and rules. The dispute resolution plan shall be reviewed at least annually and revisions made upon approval by the Commissioner.

The plan shall include the following elements:

1. The plan shall provide that PIP dispute resolution be initiated by written notice to the administrator and to all other parties of the party’s demand for dispute resolution, which notice shall set forth concisely the claims, and where appropriate the defenses, in dispute and the relief sought. **Where the arbitration is filed by a provider acting as an assignee of benefits or with a power of attorney from the insured, [The] the notice shall include proof of compliance with the internal appeal process required by N.J.A.C. 11:3-4.7B. All notices shall also include** such other information as may be required for administrative purposes;

2. - 4. (No change.)

5. The plan shall provide for the prompt, fair and efficient resolution of PIP disputes, [after a hearing by the assigned dispute resolution professional, but] **including in-person and on-the-papers proceedings in accordance with the rules of the dispute resolution organization.** The plan shall also provide that alternate procedures may be utilized when appropriate, which may include mediation, conferences to promote consensual resolution and expedited hearings upon receipt of a medical review organization report, consistent with principles of substantive law and rules adopted by the Commissioner;

6. (No change.)

7. The plan shall provide for the fair and efficient conduct of adversarial [hearings] **proceedings** when other methods of dispute resolution are either unsuccessful or inappropriate, consistent with traditional notions of due process and fundamental fairness. It shall address, at least, the following procedural issues;

i. - viii. (No change.)

(c) (No change.)

11:3-5.5 Dispute resolution professionals

(a) (No change.)

(b) Dispute resolution professionals shall avoid conflicts of interest as prohibited at N.J.A.C. 11:3-5.12 in any matter assigned to them for determination.

1. - 2. (No change.)

3. A party may challenge the assignment of a particular DRP by submitting the specific grounds for challenge in accordance with the rules of the dispute resolution organization approved by the Commissioner. **The rules of the dispute resolution organization approved**

by the Commissioner shall provide that a party may challenge the assignment of the DRP as follows:

- i. When the party receives notification of the assignment of the DRP for an in-person case; or
- ii. As part of the appeal process provided in the rules for on-the-papers cases.

(c) - (d) (No change.)

11:3-5.6 Conduct of PIP dispute resolution proceedings

(a) A request for dispute resolution of a PIP dispute may be made by the injured party, the insured, a provider who is an assignee of PIP benefits pursuant to N.J.A.C. 11:3-4.9 or the insurer, in accordance with the terms of the policy as approved by the Commissioner. The request for dispute resolution may include a request for review by a medical review organization. The request shall be made to the administrator and copies sent to other parties.

1. (No change.)
2. Providers who are the assignee of benefits by the insured or have a power of attorney from the insured shall follow the insurer's internal appeal process mandated by N.J.A.C. 11:3-4.7B before making a request for dispute resolution in accordance with (a) above. The dispute resolution organization's plan shall include a procedure for how the provider shall demonstrate that this requirement has been satisfied.

(b) Upon receipt of the request, the administrator shall promptly assign the matter to a dispute resolution professional. For in-person proceedings, [The] the administrator shall notify all parties of the DRP assigned at the time the assignment is made. For on-the-papers

proceedings, the parties will receive notice of the DRP assigned at the time the decision is issued.

(c) (No change.)

(d) Determination by the dispute resolution professional shall be in writing and shall state the issues in dispute, the DRP's findings and legal conclusions based on the record of the proceedings and the determination of the medical review organization, if any. The findings and conclusions shall be made in accordance with applicable principles of substantive law, the provisions of the policy and the Department's rules. The award shall set forth a decision on all issues submitted by the parties for resolution.

1. – 2. (No change.)

[3. The award may include attorney's fees for a successful claimant in an amount consonant with the award and with Rule 1.5 of the Supreme Court's Rule of Professional Conduct.]

(e) Pursuant to N.J.S.A. 39:6A-5.2(g), the costs of the proceedings shall be apportioned by the DRP and the award may include reasonable attorney's fees for a successful claimant in an amount consonant with the award. Where attorney's fees for a successful claimant are requested, the DRP shall make the following analysis consistent with the jurisprudence of this State to determine reasonable attorney's fees, and shall address each item below in the award:

1. Calculate the "lodestar," which is the number of hours reasonably expended by the successful claimant's counsel in the arbitration multiplied by a reasonable hourly rate in accordance with the standards in Rule 1.5 of the Supreme Court's Rules of Professional Conduct

http://www.judiciary.state.nj.us/rules/appendices/rpc.htm#P65_6482).

- i. The “lodestar” calculation shall exclude hours not reasonably expended;
- ii. If the DRP determines that the hours expended exceed those that competent counsel reasonably would have expended to achieve a comparable result, in the context of the damages prospectively recoverable, the interests vindicated, and the underlying statutory objectives, then the DRP shall reduce the hours expended in the “lodestar” calculation accordingly; and
- iii. The “lodestar” total calculation may also be reduced if the claimant has only achieved partial or limited success and the DRP determines that the “lodestar” total calculation is therefore an excessive amount. If the same evidence adduced to support a successful claim was also offered on an unsuccessful claim, the DRP should consider whether it is nevertheless reasonable to award legal fees for the time expended on the unsuccessful claim.

2. DRPs, in cases when the amount actually recovered is less than the attorney’s fee request, shall also analyze whether the attorney’s fees are consonant with the amount of the award. This analysis will focus on whether the amount of the attorney’s fee request is compatible and/or consistent with the amount of the arbitration award. Additionally, where a request for attorney’s fees is grossly disproportionate to the amount of the award, the DRP’s review must make a heightened review of the “lodestar” calculation described in (e)1 above.

[(e)] (f) The award shall be signed by the dispute resolution professional. The original shall be filed with the administrator, and copies provided to each party. If the award requires

payment by the insurer for a treatment or test, payment shall be made together with any accrued interest **ordered in the award** pursuant to N.J.S.A. 39:6A-5, within [20] **45** days of **the insurer's** receipt of a copy of the determination, **unless [an action has been filed in the Superior Court pursuant to N.J.S.A. 2A:23A-13 as] one of the actions permitted in (g) below has been filed. Where the arbitration has been filed by a provider who is the assignee of benefits pursuant to N.J.A.C. 11:3-4.7B, the payment shall be made payable to the provider.**

[(f)] (g) The final determination of the dispute resolution professional shall be binding upon the parties, but subject to **clarification/modification and/or appeal as provided by the rules of the dispute resolution organization, and/or** vacation, modification or correction by the Superior Court in an action filed pursuant to N.J.S.A. 2A:23A-13 for review of the award.

11:3-5.12 Prohibition of conflicts of interest

(a) - (e) (No change.)

[(f) For one year after the termination of professional services of any dispute resolution professional, he or she shall not appear before any dispute resolution professional representing claimants or respondents.]

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.

Recodify existing (a) and (b) as **(b) and (c)** (No change in text.)

[(c)] **(d)** This subchapter does not apply to the following:

1. - 3. (No change.)

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.** [Non-emergency outpatient services on the fee schedule, including those provided by the above facilities, are subject to 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 surgical case” means a procedure that is not minor surgery as defined in N.J.A.C. 13:35-4A.3.

...

“CDT[-3]” means the American Dental Association’s Current Dental Terminology 2011-2012, [Third Edition, Version 2000] copyright 2010.

...

“CPT” means the American Medical Association’s Current Procedural Terminology, Fourth Edition, Version [2006] **2011**, coding system. Current Procedural Terminology (CPT) is copyright [2005] **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 [provider’s] 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.

...

“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.

...

[“Outpatient surgical facility” or “OSF” means an ASC, a doctor’s office where ambulatory surgical cases are performed or a facility where non-emergency hospital outpatients are treated.]

...

“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 [Fee Schedule] **Services**, [and Exhibit 7, Ambulatory Surgical Center Fee Schedule,] are as follows:

1. – 2. (No change.)

[(b) The Regions in Appendix, Exhibit 2, the Dental Fee Schedule are as follows:

1. Region I consists of the following three-digit zip codes in New Jersey: 080, 081, 082, 083 and 084.

2. Region II consists of the following three-digit zip codes in New Jersey: 077, 078, 079, 085, 086, 087, 088 and 089; and

3. Region III consists of the following three-digit zip codes in New Jersey: 070, 071, 072, 073, 074, 075 and 076.]

11:3-29.4 Application of medical fee schedules

(a) [Every policy of automobile insurance and motor bus insurance issued in this State shall provide that the automobile insurer's limit of liability for medically necessary expenses payable under PIP coverage, and the motor bus insurer's limit of liability for medically necessary expenses payable under medical expense benefits coverage, is the fee set forth in this subchapter.] Nothing in this subchapter shall[, however,] compel the PIP insurer or a motor bus insurer to pay more for any service or equipment than the 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' [fee schedule at] services in** subchapter Appendix, Exhibit 1 [and] **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. [Trauma services means the care provided to patients whose arrival requires trauma center activation or whose care requires the consultation or services of trauma service physicians.] 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 [Surgical] services (CPT 10000 through 69999) provided in emergency care in acute care hospitals that are not subject to the trauma care exemption shall be reimbursed at 150 percent of the physician[’s]s’ fees [schedule and] in subchapter Appendix, Exhibit 1. The bills for these services shall use the modifier “-ER”. [Insurers are not required to pay for services or equipment that are not medically necessary.]

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) (No change.)

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

1. (No change.)

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) (No change.)

(e) Except as noted in (e)1 [and 2] **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. [The insurer may use national] **National** databases of fees, such as those published by Ingenix (www.ingenixonline.com), **FAIR Health** (www.fairhealthus.org) or Wasserman (<http://www.medfees.com/>), for example, [to determine] **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. (No change.)

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] the following shall apply to physician charges for multiple and bilateral surgeries (CPT 10000 through 69999), co-surgeries and assistant surgeons:**

1. – 5. (No change.)

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

7. (No change.)

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) [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 Edits, incorporated herein by reference, as updated quarterly by CMS and available at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>.]

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.

[1.] 2. (No change in text.)

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 [or purchase] 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.**

[2.] 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, [and] CPT 76140 or for the physician component of the imaging study. CPT 76140 [may only be billed] **is not reimbursable.** [where] **Where** a provider in a different practice or facility [makes] **performs a medically necessary** review[s] 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.

[3.] **8.** When CPT [76005] **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**.

[4.] **10.** (No change in text.)

[5.] **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**.

[6.] **12.** (No change in text.)

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) – (l) (No change.)

(m) The daily maximum allowable fee shall be [\$99.00] **\$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. – 5. (No change.)

(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 [(o)1] **(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. - 4. (No change.)

[(o) ASC facility fee group numbers are indicated by CPT code on the physician's fee schedule, subchapter Appendix, Exhibit 1. The facility fees are listed in subchapter Appendix, Exhibit 7. If a procedure can be performed in an ASC but it is not listed in the physician's fee schedule, the ASC facility fee for the procedure shall be the fee group in Appendix, Exhibit 7 that includes procedures similar to the unlisted procedure. For example, if an injection code is not included in Appendix Exhibit 7, the facility fee for the procedure would be the same as for other injection codes that have a group number. In no case, shall a facility fee be greater than the highest facility fee on the schedule (Group 9). If a CPT code is subsequently assigned an ASC group number by Medicare, as found in <http://www.cms.hhs.gov/ascpayment/>, the facility fee for that code shall be that of the same group number in Appendix, Exhibit 7. If a CPT code is subsequently assigned to an ASC group number by Medicare, as found in <http://www.cms.hhs.gov/ascpayment/>, the facility fee for that code shall be that of the same group number in Appendix, Exhibit 7. The ASC facility fee includes services that would be covered if the service were furnished in a hospital on an inpatient or outpatient basis, including:

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

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

3. Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment;
4. Diagnostic and therapeutic items and services;
5. Administrative, recordkeeping, and housekeeping items and services;
6. Blood, blood plasma, platelets, etc.; and
7. Anesthesia materials, including the anesthetic itself, and any materials, whether disposable or re-usable, necessary for its administration.

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

1. The sale, lease or rental of durable medical equipment (DME) to ASC patients for use in their homes. If the ASC furnishes items of DME to patients, billing for such items should be made in accordance with subchapter Appendix, Exhibit 5; and

2. Prosthetic and other devices, including neuro-stimulators, internal/external fixators, tissue grafts, plates, screws, anchors and wires, whether implanted, inserted, or otherwise applied by covered surgical procedures. Such prosthetics and devices shall be billed at invoice plus 20 percent.

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

(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) **[Outpatient surgical facility fees] ASC facility fees are listed [on the Physicians' Fee Schedule] in Appendix, Exhibit 1, by CPT code. [The outpatient surgical facility fee is the maximum that can be reimbursed for outpatient procedures regardless of whether they are performed in a hospital outpatient facility, an ASC or a physicians' office.] Codes [on the Physicians' Fee Schedule] that do not have an amount in the [outpatient surgical] ASC facility fee column [cannot be performed in such facilities] are not reimbursable if performed in an ASC. The [outpatient surgical] ASC facility fee include[s] 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[s,]. Appendix, Exhibit 1[the Physicians' Fee Schedule] 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 (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 a HOSF;

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

6. Blood, blood plasma, platelets, etc.; [and]

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

[(b)] (c) [The following services are not included in the outpatient surgical facility fee:

1.] **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 [outpatient surgical facility] ASC or HOSF furnishes items of DME to patients, billing for such items should be made in accordance with subchapter Appendix, Exhibit 5[; and**

2. Prosthetic and other devices must be billed in accordance with N.J.A.C. 11:3-29.4(f)8.]

[(c)] (d) **When multiple procedures are performed in an [outpatient surgical facility] in an ASC or in an HOSF in the same operative session, the [outpatient surgical] 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 [Appendix], Appendices, Exhibit 1, the Physicians' and [Outpatient Surgical] ASC Facility Fee Schedule and Exhibit 7, the HOSF fee schedule, indicate[s] those CPT codes that, according to Medicare (see: www.cms.gov/ASCPayment/ASCRN/list.asp), are exempt from the multiple procedure reduction formula.**

