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

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

(c) These fee schedules do not apply to the following:

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

2. Any other kind of insurance including health insurance, even when the health insurer may be required pursuant to its health insurance contract to pay benefits to, or on behalf of, a person who sustained bodily injury as a result of an accident while occupying, entering into, alighting from or using an automobile or motor bus, or as a pedestrian, caused by an automobile or motor bus or an object propelled by or from an automobile or motor bus; and

3. Medical services or equipment provided outside of the geographic boundaries of New Jersey except as set forth in N.J.A.C. 11:3-29.4(d)2.

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:

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

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

performed through its own separate incision.

"CDT-3" means the American Dental Association's Current Dental Terminology, Third Edition, Version 2000.

"CPT" means the American Medical Association's Current Procedural Terminology, Fourth Edition, coding system.

"Eligible charge or expense" means the provider's usual, customary and reasonable charge or the upper limit in the fee schedule, whichever is lower.

"Emergency care" means all medically necessary treatment of a traumatic injury or a medical condition manifesting itself by acute symptoms of sufficient severity such that absence of immediate attention could reasonably be expected to result in: death; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. Such emergency care shall include all medically necessary care immediately following an automobile accident, including, but not limited to, immediate pre-hospitalization care, transportation to a hospital or trauma center, emergency room care, surgery, critical and acute care. Emergency care extends during the period of initial hospitalization until the patient is discharged from acute care by the attending physician.

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

"HCPCS" means the Federal Health Care Financing Administration's (HCFA's) Common Procedure Code System.

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

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

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

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

1. The medical treatment or diagnostic test is consistent with the clinically supported symptoms, diagnosis or indications of the injured person;

2. The treatment is the most appropriate level of service that is in accordance with the standards of good practice and the provisions of N.J.A.C. 11:3-4, as applicable;

3. The treatment is not primarily for the convenience of the injured person or provider;

4. The treatment is not unnecessary; and

5. The treatment does not include unnecessary testing.

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

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

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

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

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

11:3-29.3 Regions

(a) Region I, as used in this subchapter, consists of the following three- digit zip codes in New Jersey: 080, 081, 082, 083 and 084.

(b) Region II, as used in this subchapter, consists of the following three- digit zip codes in New Jersey: 077, 078, 079, 085, 086, 087, 088 and 089.

(c) Region III, as used in this subchapter, 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 provider's 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. The fee schedules set forth at N.J.A.C. 11:3-29 Appendix, Exhibits 1 through 5, incorporated herein by reference, shall not apply to inpatient services provided by

acute care hospitals, trauma centers, rehabilitation facilities, other specialized hospitals, residential alcohol treatment facilities and nursing homes, reimbursement of which shall be limited to the provider's usual, customary and reasonable fees. The physicians' fee schedule at subchapter Appendix, Exhibit 1 shall not apply to services provided in emergency care at Level I and Level II trauma hospitals. Insurers will not be required to pay for services or equipment that are not medically necessary.

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

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

1. The insurer's total limit of liability for the rental of a single item of durable medical equipment set forth in the schedule is 15 times the monthly rental fee.

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

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

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

(e) 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. 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.

(f) Except as provided in (m) below, the following shall apply to multiple and bilateral procedures:

1. When multiple or bilateral procedures are performed on the same patient by the same provider at the same time or during the same visit, it is virtually never appropriate for the fee to be the sum of the fees for each procedure. The primary procedure at a single session shall be paid at 100 percent of the eligible charge, the second procedure at no more than 50 percent of the upper limit in the fee schedule for that particular procedure, and if performed, any additional procedures at no more than 25 percent of the upper limits in the fee schedule for those particular procedures.

2. Procedure codes denoted as "each additional" are valued as listed and are not subject to the multiple and bilateral procedures guidelines.

3. If two or more providers in different specialties perform procedures or if one provider performs multiple procedures on different body parts or regions, each individual provider, or each individual body region or body part procedure may be reimbursed separately. For purposes of such billing, the body shall be divided into: head (including skull and brain); face; neck; chest; abdomen; back; and pelvic regions. In addition, the extremities shall be subdivided into right and left: upper arm, elbow, forearm, wrist and hand; and thigh, knee, lower leg, ankle and foot. This reference to specific body parts or regions is included as a guideline to be used in billings for operative and surgical procedures. It is not intended to apply to nor should it be used in connection with billings submitted for non-surgical services provided during the same visit except as a means of describing the treatment rendered.

4. Nothing in this subchapter shall be construed to prevent PIP insurers or motor bus insurers from paying only reasonable and appropriate fees when multiple procedures are performed at the same time or multiple services provided during the same visit.

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

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

(i) CPT codes for unlisted procedures or services (example: 97139 Unlisted therapeutic procedure) are not reimbursable without documentation describing the procedure or service performed, demonstrating its medical appropriateness and indicating why it is not duplicative of a code for a listed procedure or service.

(j) The insurer's limit of liability for medically necessary assistant surgeon expenses shall be 20 percent of the primary physician's allowable fee determined pursuant to the fee schedule and rules. Assistant surgeon expenses shall be reported using modifier -80, -81 or -82 as designated in CPT. When the assistant surgeon is someone other than a physician surgeon, the reimbursement shall not exceed 85 percent of the amount that would have been reimbursed had a physician surgeon provided the service. These services shall be reported using modifier-AS as designated in HCPCS.

(k) When two physician surgeons are required for a specific surgical procedure, the separate services claimed by each surgeon shall be reported using the modifier -62 as designated in CPT. Total eligible expense shall equal
150 percent of a single practitioner's eligible expense amount for the surgical procedure performed, to be divided equally between the two surgeons.

(l) The professional component of global service charges shall be reported using modifier -26 as designated in CPT. Services with professional component amounts of zero in the fee schedule are considered to be 100 percent technical. The technical component is the difference between the global service and the professional component amounts listed in the fee schedule.

(m) The daily maximum allowable fee shall be $90.00 for 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. However, an insurer is not prohibited from reimbursing providers in excess of the daily maximum where the severity or extent of the injury is such that extraordinary time and effort is needed for effective treatment. 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. 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.

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

(o) 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 through 4 below is present and not more than twice in any 30 day period. Modifier -25 shall be added to an evaluation and management service when a significant separately identifiable evaluation and management service is provided and documented as medically necessary as follows:

1. There is a definite measurable change in the patient's condition requiring

significant change in the treatment plan;

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

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

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

11:3-29.5 Balance billing prohibited

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