This is my decision in the matter of the Burn Surgeons of St. Barnabas vs. Shoprite, as insured by New Jersey Manufacturers Insurance Company (NJM). This is a dispute over medical bills, the manner in which they are paid and the amounts which were in fact paid. The worker, G.T. was a severely injured man who was injured in a compensable accident. Shoprite admitted liability and authorized the Burn Surgeons of St. Barnabas Hospital to treat the worker. G.T. has not yet filed a claim petition for his injuries. The issues to be decided in this case are: 1. Was it appropriate that the Burn Surgeons at St. Barnabas submit bills to NJM listing the two surgeons who performed surgery on the worker on the five dates as co-surgeons rather than as a primary surgeon and an assistant surgeon; 2. Did NJM apply the appropriate modifiers to the CPT codes and the multiple procedure reductions; 3. Did NJM pay the usual, customary and reasonable rate for the treatment rendered to the injured worker and finally 4. Does NJM owe any further money to the Burn Surgeons of St. Barnabas?

N.J.S.A. 34:15-15 provides that the employer shall furnish to the injured worker such medical, surgical and other treatment as shall be necessary to cure and relieve the worker of the effects of the injury. These charges are to be reasonable and based upon the usual fees and charges which prevail in the same community for similar physicians, surgeons and hospital services. No detailed contract exists between NJM and the Burn Surgeons of St. Barnabas. Both parties place reliance on the interpretation of usual, customary and reasonable. At the outset of the worker's treatment, NJM sent a letter to the Burn Surgeons of St. Barnabas authorizing them to care for the worker and to bill at the usual, customary and reasonable rate. The surgeons involved in this action are individuals who treat burn victims. Their expertise is exclusively

within the field of burn treatment. The Burn Surgeons of St. Barnabas have operating facilities at St. Barnabas Hospital; they receive burn victims from the northern part of New Jersey. Their geographic area encompasses all of New Jersey north of the Raritan River. Burn cases in need of treatment south of the Raritan are sent down to Crozier Chester Hospital Burn Center.

In order to establish uniformity in billing for medical services nationwide, a coding system has been created by the American Medical Association for the benefit of doctors, insurers and patients. Medical procedures have been identified and reduced to single identifiable tasks and assigned specific codes. The codes are accumulated in the CPT Manual. CPT stands for Current Procedural Terminology. These codes, in number form, exist for every task and service that a doctor can perform on behalf of his patient. The manual is updated yearly by the American Medical Association.

The Burn Surgeons at St. Barnabas Hospital use a relatively small number of codes in their daily practice. The surgeons herein have limited their claim for further payment to 6 CPT codes: 15000, 15001, 15100, 15101, 15120 and 15121. When any of the Burn Surgeons at St. Barnabas Hospital perform any of the above listed procedures, the code is listed on the billing form commonly known as a HCFA. The medical provider can set its own standard fee schedule for these codes. The payers however do not necessarily pay the provider's charge in full.

The Burn Surgeons at St. Barnabas Hospital produced Dr. Michael Marano as its first witness. Dr. Marano is an attending surgeon employed at the Burn Surgeons and is Board Certified in

general surgery and surgical critical care. He has had extensive training in the field of burn treatment. Dr. Marano qualified as an expert in general surgery and critical care surgery without objection from respondent. Dr. Marano testified about the specialized nature of his practice. The Burn Center at St. Barnabas is the only burn center in Northern New Jersey. He follows burn patients from admission through surgery, post-surgical therapy to discharge. Burn patients can have many complications in their treatment. Infection is a major cause of death. Organ failure is the second most cause of death in burn patients.

Dr. Marano testified that these two complications warrant significant consideration and treatment plans developed for burn patients. In his opinion, the shortest period of time to excise the burns and to graft the wounds gives the patient the best chance of survival.

Dr. Marano testified that the procedures used in conducting a grafting surgery from the removal of the old dressing and cleaning the wounds to the transport to the grafting theatre. He testified about the conditions in the theatres specifically that the room is maintained at 90 degrees for the protection of the patient. Patients without skin cannot maintain their own body temperatures. Surgeons wear cooling vests so they can work in the operating theatre.

At the start of the surgery the patient is carefully positioned. There is an anesthesiologist present. In some cases, residents and medical students attend. Dr. Marano testified that in large burn cases two burn surgeons attend.

Dr. Marano testified that the residents assist in positioning the patient but they cannot work independently. In the surgery there would be at least two operating room nurses, a scrub nurse in sterile garb who can assist in the procedures and a circulating nurse who can obtain necessary equipment and products such as blood. In regard to co-surgeons, Dr. Marano testified that the need for co-surgeons depending on the amount of surface area that needed to be addressed during that procedure. In his opinion, "the larger the surface area, the more blood lost, the more time it takes, the more complex the procedure is, the sicker the patient is."

In these cases, Dr. Marano testified that the practice was "to have two experienced people working simultaneously, but sharing responsibility." Dr. Marano testified that there were many burn procedures that do not require two attending surgeons. These are cases that are smaller surface area and are often performed on patients who are not particularly ill in a step down unit, not an operating theatre.

Dr. Marano testified that the shorter period of time in surgery, the better for the patient. He asserted that fewer trips to the operating room, fewer anesthetics, few hypothermic insults and fewer blood products benefit the patient.

Another reason the burn surgeons utilize two attending surgeons would be the location on the body where the graft is to occur. A graft to the upper extremity would not require co-surgeons in his opinion. If a greater area was involved such as both arms, more can be accomplished than if just one surgeon was working. Burn surgery differs from other types of general surgery

in that the task to be accomplished can be interrupted in the event that the patient's condition deteriorates during surgery. Surgeons measure the patient's status by observing blood pressure, pulse rate, temperature and urine output. Blood loss is also crucial. Dr. Marano described the manner in which the two surgeons work together. He made it clear that the patient is not divided in half (with one surgeon taking one side and the other surgeon taking the other). Dr. Marano described the procedures for grafting, wound cautery, utilization of temporary skin, splinting and post-surgical care. In obtaining graft material one surgeon excises skin, the other then steps forward to control blood loss. Blood loss is controlled through the use of topical thrombin material and cautery. In his opinion, it would not be a good idea for both surgeons to be excising at the same time. However, he testified that two surgeons work as co-equals in the operating room. Dr. Marano is familiar with the case of the worker, G.T. Mr. T suffered an injury consisting of 43% of total body surface with flame burns and severe smoke inhalation. Third degree burns involve the entire thickness of the skin and require surgery with excision and grafting. The worker was considered critically ill from the time of admission. He needed aggressive volume resuscitation with intravenous fluids. He needed a tracheostomy for stabilization of his airway. The worker also suffered from renal problems. Mr. T had his first surgery on December 27, 2004. He had a tracheostomy and excision and split thickness grafting for third degree burns of the left arm and hand. The two surgeons on these procedures were Doctors Petrone and Mansour.

Dr. Marano testified that two surgeons were needed for the tracheostomy because of the damage to the worker's airway. Apparently this procedure was not billed for two co-surgeons.

The first surgery had to be stopped because of blood loss. The operative note marked as P-6 noted that the petitioner tolerated the procedure well.

The petitioner had a second surgery on January 3, 2005 for excision and split thickness skin grafting of third degree burns on the anterior torso, flanks and left shoulder. Dr. Marano felt that two attending surgeons were appropriate because on the torso tourniquets could not be used and the surface area was quite large.

The patient had a third procedure on January 10, 2005. This accomplished an excision of third degree burns of the left lower extremity and right upper extremity and right hand with split thickness grafting. The large surface area and various extremities called for two attending surgeons in Dr. Marano's opinion.

The next surgery took place on January 17, 2005. This procedure involved excision and split thickness grafting for third degree burns of the back and left shoulder. Dr. Marano testified that two attending surgeons were needed on these procedures because he was positioned prone and required additional maneuvers. Also, Dr. Marano testified that tourniquets could not be used during this procedure.

The fifth surgical procedure took place on January 20, 2005. The injured worker received excision and split thickness grafting on his interior torso left thigh and left posterior leg.

Dr. Marano testified that it would be possible to treat the worker with only one attending physician but this would not be in the patient's best interest. In his opinion, the patient would have needed almost double the amount of operative procedures with an increased risk of infection and organ failure. Dr. Marano was not aware of any protocol that required the use of two attending surgeons, but in his experience these types of surgery require a team effort. In his experience, Dr. Marano admitted that during his training he did not always have to attending co-surgeons in the procedure but would have had the assistance of a fellow. A fellow is a board certified general surgeon.

Dr. Marano concluded his direct testimony with the express opinion that the patient benefitted from the surgeries performed by the Burn Surgeons at St. Barnabas.

On cross-examination, Dr. Marano testified that there were no board certifications for burn surgery. Dr. Marano stated that to qualify for certification which he must do every 10 years he must submit a case log which shows the number of times that he has served as an operating surgeon. Acting as an assistant surgeon would not count towards re-certification.

Dr. Marano's income is derived partly from payments from the St. Barnabas Hospital and partly from his medical services provided to burn patients.

Dr. Marano testified that the burn center treated 400 patients per year. He was not certain of the specific causes of their burns or the distribution of their ages.

Dr. Marano is a member of the American Burn Association and he participates in their meetings and with research. He was not aware of any protocols for treatment to burn victims issued by the American Burn Association other than transfer criteria. He was familiar with the American Burn Association White Paper. Dr. Marano indicated that he did agree with the definitions but took issue with the section on skin substitutes. Skin substitutes were not used in this particular case. He also was not familiar with the codes listed in the appendix of the White Paper.

He testified that his group, the Burn Surgeons of St. Barnabas, use single stage excision and grafting on the vast majority of their patients, regardless of how sick the patient is. This, he acknowledged was contrary to the treating regimen recommended in the American Burn Association White Paper. Dr. Marano characterized a small burn as a one to ten percent area of the body in surface area, 15 to 35% was a medium size burn and above 30 to 35% in his opinion would be considered substantial. He acknowledged that the injured worker had a large size burn with the complication of smoke inhalation.

When asked about the blood loss, Dr. Marano agreed with the conclusion on the White Paper which gave the amount of blood lost during a single stage procedure as a reason not to do single stage procedures. The worker lost 4 to 6 units of blood per surgery. Two units of blood equals one quart. Humans have only 5 quarts of blood.

Dr. Marano testified that the blood loss can be dependent on whether tourniquets were used on the area of the body affected. The anesthesiologist is responsible for monitoring blood loss. Dr. Marano testified that communication between the surgeon and the anesthesiologist is crucial during surgery. The surgeon participates in the decision when to give blood, how much to give, other medication to support blood pressure up to and including the length of the surgery.

Dr. Marano testified that he records his activities in the operating room and the bill for services is prepared based on his report. In regard to this injured worker, the doctor did multiple single stage procedures, no skin substitute was used, and procedures were carried out pursuant to a case care plan. Any of the surgeons at the Burn Surgeons could substitute for other as all are familiar with the injured worker's case. Dr. Marano indicated that the surgeries were each approximately one week apart.

Dr. Marano acknowledged that some hospitals do not use a team approach and that the team approach was not recommended by the American Burn Association White Paper. He acknowledged that the White Paper did not have a protocol that suggested the use of co-surgeons and despite this the Burn Surgeons at St. Barnabas elected to use co-surgeons in their procedures. Dr. Marano was given an opportunity to review P-3, a letter prepared by the Burn Surgeons to be sent to all commercial carriers. This document was an acknowledgement by the

Burn Surgeons of St. Barnabas that skin grafting codes have not been approved for second surgeon's fee. This document was sent with the accompanying bills.

Dr. Marano was asked about the surgery he performed with Dr. Petrone on January 3, 2005. The total amount excised was 3,216 square centimeters. He could not identify which excisions he had performed and which had been performed by Dr. Petrone. Each surgeon, however, billed separately for the entire amount of site prep. Dr. Marano admitted there was no grafting to the worker' s face, scalp, eye lids, mouth, neck area, ears, orbits, genitalia or hands in the first January 3, 2005 surgery.

The January 8, 2005 surgery grafted 1,997 square centimeters. Dr. Marano could not identify the grafting that he had done from that done by Dr. Petrone.

When specifically questioned about the activity of each surgeon, Dr. Marano testified that the surgeons alternated components of the surgery but did not do two excisions at the same time. Dr. Marano was not aware of any written protocols or policies governing the number of surgeons necessary for this surgery. In his opinion the need for the second surgeon was governed by the extent of the burn, the current status of the patient and the area of the body. Dr. Marano had limited knowledge of billing codes and the factors involved in determining the surgeons compensation. Dr. Marano defined co-surgeons as two individuals working together on a project sharing responsibilities. Dr. Marano was not aware of the Medicare guidelines for

the use of co-surgeons. Dr. Marano testified that while one surgeon is doing the excision or grafting, the second surgeon is assisting blood loss, blood pressure and pulse rate.

He testified "I would say it's a more a multi-tasking kind of process. They are not singular responsibilities. If I see my partner is engaged in a technical procedure, then I know it's my responsibility to watch and estimate and keep an eye on things during that period of time and visa versa." It was Dr. Marano's understanding that the total amount of skin excised is billed by each surgeon by the billing office. Dr. Marano opined that two surgeons would not be necessary for a case of grafting less than 1,000 centimeters. When asked about the use of co-surgeons on Medicare patients, Dr. Marano could not explain why every Medicare patient billed used an unlisted procedure code instead of the standard code used on the other bills. He was aware that bills were sent out to patients and carriers and that some percentage of that bill would be paid.

Dr. Marano conceded that he was aware that carriers negotiated their bills. He was aware of a contract between the Burn Surgeons and Blue Cross/Blue Shield and testified that he was a signatory to it. He was not aware of the specific amounts paid by Blue Cross/Blue Shield on Medicare or Medicaid for his services. He was aware of the existence of the burn surgery center at Crozier Chester, the Temple Burn Center and the New York Burn Center but was unaware of any billing rates or reimbursements standards used by these facilities.

The petitioner next introduced Claribel Gonzalez. Ms. Gonzalez is the billing supervisor at the Burn Surgeons at St. Barnabas Hospital. She has been employed by Burn Surgeons for approximately 6 years. Her duties included billing and follow up with insurance companies and patients for payment.

Ms. Gonzalez identified several health insurance claim forms (HCFAs) issued by the Burn Surgeons of St. Barnabas representing charges for services rendered on behalf of the injured worker, G.T.. These forms were sent to NJM Insurance Company. These exhibits were moved into evidence. Next she identified the explanation of benefits forms which were sent to the Burn Surgeons of St. Barnabas by NJM. These EOBs are the responses to the claim forms returned to the service providers by the carriers. These are standard forms used throughout the medical industry. These explain the allowances for payment by the carriers. The EOBs were admitted into evidence as P-12.

In preparation for prosecution of this claim, Ms. Gonzalez prepared a spread sheet to show the billing information on patients who receive surgery by co-surgeons from the Burn Center. These are for surgeries which took place at the end of 2004 and early 2005.

The spread sheet showed how much was billed and how much was paid for all surgeons and co-surgeons in 2004-2005 as paid by workers' compensation and commercial carriers. The sheet did not include Medicaid or Medicare cases.

The petitioner produced HCFAs and EOBs for patient JM for a surgery dated March 4, 2004. The HCFA on this case contained charges for the first surgeon and then charges for a second surgeon. Ms. Gonzalez testified that she knew that a second surgeon participated because the HCFA contained a notation of 62 in the modifier column. With the exception of charges for a tracheostomy and splint, the charges for both surgeons were identical. This bill was submitted to Zurich Insurance Company. The next HCFA, marked as P-13B, produced was for services rendered for patient DI and submitted to Coresource. Ms. Gonzalez produced EOBs for another patient, TA. This EOB contained an explanation for surgical services provided on March 25, 2004. The codes used were 15000, 15001, 15100 and then 15101. There was a charge for code 29799 (splinting). Ms. Gonzalez testified that the total billed charges were $15,215 for surgeon one, and $15,550 for surgeon two. Ms. Gonzalez could not locate the EOBs for some additional payments made by the carrier. She did not produce the HCFA relating to these EOBs. P-13D was an EOB for date of service, April 19, 2004 for patient BW and submitted to payment to NJCE. It contained charges for both surgeons Dr. Marano and Petrone. This bill contained codes 15000, 15001, 15100, 15101. There was also a charge on this bill for splinting.

The first page of the bill marked as P-13E for patient DP contained provider codes, The Burn Surgeons of St. Barnabas' total charges and what was allowed by the carrier. The second page contained a charge for a splint as performed by the first surgeon. The third page reflected the charges for the services of the second surgeon. This charge utilized a 62 modifier as well. P-13F contained the surgical codes, the charges by the Burn Surgeons at St. Barnabas and two modifiers, 62 and 58. The 62 modifier indicated the use of a second surgeon; the 58 modifier

alerted the carrier that the surgery was a staged procedure, meaning that the patient would be returned the operating room for an additional procedure at a later date. Although both pages contain the same procedure for D.S. on June 3, 2004 the billed amounts differed. The first billed amount was $26,402. On the second page, $26,150 was billed. There were additional EOBs from this patient for surgery dates June 7, 2004, June 14, 2004 and July 1, 2004.

Ms. Gonzalez testified about P-13G which was an EOB for patient G.P. for a date of service August 19, 2004. She also identified P-13H as an EOB for patient A.M. for a date of service October 6, 2004. This EOB contained the charges for the first surgeon, the reductions by the carrier and a copy of the check.

The petitioner then produced Claudette Mansour. Ms. Mansour is the practice manager for the Burn Surgeons of St. Barnabas and is married to Dr. Mansour, a senior member of the practice. She is closely involved in the creation of the fees charged by the group. In her words, she "creates resources for them to use to establish a fee". She is a member of the American Burn Association and she has served on the Federal Issue Committee and the Coding Committee. She testified that she is not nor is anyone on her staff a certified coder. She did testify about how the group determines its yearly fee increase. According to Ms. Mansour she takes the current year's fee and multiplies it by a percentage chosen after consultation with Dr. Mansour. The percentage is usually somewhere between 3 and 5%. Ms. Mansour testified about the use of the relative value scale and resources such as St. Anthony's and the Health Care Consultants. She testified about how the value is attached to a code. For example; a code is provided with a

relative value and then multiplied by a conversion factor to determine the dollar amount. The dollar amount then becomes the bill for services. Ms. Mansour testified that she utilized both the St. Anthony's and the Health Care Consultants data to set fees for the Burn Surgeons of St. Barnabas. The Burn Surgeons used the same fees in 2003 and 2004. Ms. Mansour testified that she would sit with a surgeon and look at codes. They would then decide the annual increase of their fees based on their subjective opinion as to the value of the services offered. Some fees would be increased, some would remain the same. She could not testify as to how many self-paid patients actually paid. Patients who were indigent would get the Medicaid fee schedule. There were a large number of self-paid patients in her opinion. Medicare and Medicaid fees were considered contracted rates and were not considered when calculating increases. Also the Burn Surgeons contracted with Blue Cross/Blue Shield and did not use the fees set in that agreement in the calculation for any increase in fees for the commercial carriers. For the balance of the other payers, the Burn Surgeons were considered out of network. A medical provider considered in network has a contractual agreement and an agreed upon rate. The Burn Surgeons of St. Barnabas send out their bills for service and then they are paid on their contracted fee schedule. Ms. Mansour testified that even in fee schedule cases there are times that the payments need to be appealed.

Ms. Monsour testified about The Burn Surgeons' process for developing their bills. A work sheet takes in charges for the services rendered to a patient; work sheets are kept with the billing charts. The work sheet is drafted by Dr. Sylvia Petrone, regardless of whether she was a participating surgeon. Each surgeon completes a slip on conclusion of surgery. Dr. Petrone

enters the information into the billing database. Dr. Petrone assigns the appropriate codes for the work done. Any modifiers that are assigned are assigned by the billing staff, not the doctors. Specific modifiers are defined in the CPT Manual. Ms. Mansour could not explain the difference between a modifier 80 assisted surgeon and a modifier 62 co-surgeon. She was not aware of the billing practices of other burn surgery centers. Ms. Mansour has no formal training in coding or any experience other than on the job experience for fee setting. She testified that she was "overwhelmed by billing". According to her, the factors used in billing were Medicare policies, geographic region, the particular specialty of the physicians, complexity of service rendered, severity of the illness and the patient mix. She testified that the fees were adjusted to reflect ability to pay. The CPT codes include consideration for pre-op and post-op care and the specific code assigned to the surgery. The care provided in the 90 days post-surgery for major procedures is included in the billing for the primary procedure code used. Secondary and add on codes do not include pre or post-op care. This continued care is referenced as the global period.

In the end, to set the fee, the Burn Surgeons use the increased percentage chosen by Ms. Mansour and a doctor from the group, the two relative value scales and a range chosen by the Burn Surgeons. Ms. Mansour testified that the bills submitted to Medicare do not contain procedure codes. The Medicare bills are priced manually; co-surgeons are paid on a Medicare fee schedule; specifically 100% for the first surgeon, 60% for the second surgeon. Ms. Mansour described this as an enhanced fee supported by special billing procedures. She did

acknowledge that Medicare will not approve co-surgeons for certain codes used by the Burn Surgeons.

Ms. Mansour testified that she understood that no matter how many surgeons participate reimbursement is based on the total units grafted. Ms. Mansour was aware that CMS rules allow reimbursement at 62 1/25 of usual, customary and reasonable when co-surgeons are allowed. She did acknowledge that Medicare would not approve a co-surgeons charge for code 15000 or code 15100. In her opinion, the two burn surgeon physicians were fully engaged in the grafting procedure and worked on it together.

Ms. Mansour was unaware of the Ingenix approach to calculating a fee with an attached 62 modifier. She recognized that CMS and the AMA used the 51 modifier to indicate multiple procedures that allow payment in full for the primary code; secondary codes are reimbursed at 50%. In these particular surgeries for G.T., the primary code for grafting was 15100. This represented the charge for one unit, the first 100 square centimeters of graft material. The add on code for additional units would be 15101. One unit equals 100 square centimeters. Depending on the area to be grafted, the primary code would be 15120 for delicate areas or code 15100 for the rest of the body.

Ms. Mansour testified that she did not know that CMS guidelines were used by the NJ PIP Act. She was not aware that CMS requires a separate operative note documenting the necessity of the second surgeon. She did not acknowledge that CMS was the sole source for establishing

the percentage of the 62 ½% for a 62 modifier. Ms. Mansour argued that special consideration should be given to the Burn Surgeons because they work with critically ill patients. She testified that each surgeon bills for the entire grafting done during the operative procedure not just the grafting done by that individual surgeon.

On continued cross examination, Ms. Mansour acknowledged that Dr. Petrone assigns the codes but does not note whether the second surgeon is in the operating theatre acting as a co-surgeon or as an assistant surgeon. Ms. Mansour testified that the Burn Surgeons do not bill assistant surgeons so that if two surgeons are used in the theatre, the bills would always reflect co-surgeons.

On July 20, 2010 Ms. Claribel Gonzalez returned for further cross examination. Ms. Gonzalez testified that she only had on the job training. She had no formal course work in coding and has not taken any tests for certification. On cross examination she testified about the data entry into the Burn Surgeon system and acknowledged that any time two surgeons participate in any surgery the bill would mark the code with a 62 modifier indicating use of co-surgeons. She identified modifier 62 and 58 but was unable to define 51 or 22.

She testified that the biller used the worksheets prepared by Dr. Petrone to prepare the bills. She did not recall who prepared the bills for the injured worker in this case. The worksheet for the December, 2004 surgery for this injured worker was not preserved. Ms. Gonzalez testified at length concerning the procedures she used to create her spread sheets. The charts prepared

as P-27 did not include bills to Medicare, Medicaid, Blue Cross Blue Shield or PIP. She testified that the spread sheet was not complete as she found more pertinent patient records since her first testimony. On cross examination and while referring to the HCFAs and EOBs that were in evidence before this court, Ms. Gonzalez testified to several examples of accepted payment by the Burn Surgeons from commercial carriers which were less than the payments made by NJM for similar codes. Ms. Gonzalez testified that for the patient referenced in P- 13 S; specifically the HCFAs and EOBs for P-13S, GE Healthcare paid the first surgeon, Dr. Marano $450 against the $800 billed but did not make any payment to Dr. Petrone who also participated in that surgery and who also billed $800. Dr. Petrone was not paid anything for this surgery. Dr. Petrone however, was allowed $126 for this splint she fashioned during the surgery.

Similar examples were demonstrated with the commercial carriers specifically Norton Insurance and United Health Care. The EOB from United Health Care contained the code "I-21" and the remark "these services are not eligible for a co-surgeon." Ms. Gonzalez acknowledged that a review of the EOB submitted as R-23 representing payments accepted by the Burn Surgeons from Blue Cross /Blue Shield reflected a per unit average of $139.33 for the code 15000 but that additional payments for these EOBs were made subsequent to receipt of the initial payment. The information regarding subsequent payments was not provided to the respondent during the discovery process. Apparently the Burn Surgeons received a lump sum amount from Blue Cross and Blue Shield subsequent to the initial payment for these specific EOBs. Application of these monies was never established.

Next, respondent's counsel turned her attention to code 15001 the surgical preparation code for an initial 100 square centimeters of site preparation. This is an add on code for code 15000. Ms. Gonzalez noted that the Burn Surgeons billed 15001 with the modifier 62 and 68 on each of the injured worker's surgeries. Ms. Gonzalez acknowledged that CMS rules do not allow a co-surgeon for this work. At the time in question, the Burn Surgeons billed $300 per unit and received $190.62 or $187.50 from NJM, approximately 63% of the amount billed. A review of the other commercial carriers' payments including Liberty Mutual and AIG as evidenced by exhibits P13-J, P13-J1, P13-Q, and P13-C showed a range of $99 per unit to $266.67 per unit all accepted by the Burn Surgeons. For this code, Selective Insurance paid $194.80 per unit, AIG Chartis paid $200.67 per unit or 67% of the bill charged, Sedgewick paid $146.70 per unit or 48% of the billed amount, Garden State paid $195.60 or 65% of the billed amount and finally Aetna paid $187.50 or 62% of the billed amount.

Charges by the Burn Surgeons were consistent; payments were consistent as well, usually in the range of 60 to 65%. The Burn Surgeons accepted an average of 54.97% from Blue Cross Blue Shield for procedures with the code 15001.

The next code considered during Ms. Gonzalez' cross examination was 15100, a surgical grafting code. This code represents the first 100 centimeters of skin grafting onto the trunk of the body, the arms or the legs. This is an initial charge. Subsequent grafting units are considered under code 15101, an add on charge representing multiple graft units. Ms. Gonzalez acknowledged that CMS guidelines do not permit co-surgeons on this procedure. The

Burn Surgeons charge $1,450 per unit for code 15100. The usual customary and reasonable allowance from Ingenix for this code was $2,183 per unit in 2004 and $1,900 per unit in 2005. NJM's reimbursement per unit was $1,364.38 in 2004 and $1,187.5 in 2005. Ms. Gonzalez conceded that Liberty Mutual paid $693.97 per unit for this code in 2004 and $505.00 per unit for this code in 2005 on cases they had with the Burn Surgeons. AIG Chartis paid $702.35 for this code for a date of service July 19, 2004 as shown in P-13T. Sedgewick paid $684.60 per unit for this code or 47% of the charge. In P-13U, Garden State Insurance paid $684.60 or 47% of the billed about on the charges assessed against them in 2004.

The payment for code 15100 is dependent on whether there is a second procedure done which is considered a higher procedure. On the Garden State EOB, the primary code was 15120 which would be paid at 100% under accepted billing procedures. On that date of service, 15100 was a lesser code which would have been paid at 50%. Ms. Gonzalez testified that the balances unpaid by the insurance carriers are forwarded to the patient for payment or in some cases placed in suit with their attorney. Ms. Gonzalez testified that United Health Care adopted CMS guidelines in 2006 and did not pay for co-surgeons after that date. The average per unit payment for code 15100 from Blue Cross Blue Shield for this time period was $500.17. NJM would pay $1,364.38 per unit for this code under their payment plan. Other carriers paid $500 per unit and Ms. Gonzalez conceded that the average payment for code 15100 was in fact $500 per unit in 2004.

Because of the CMS Guidelines, the Burn Surgeons does not bill for co-surgeons on any Medicare cases unless codes 15120 and 15121 are involved. The Burn Surgeons also has an arrangement with certain carriers to allow a discount for prompt payment. The Burn Surgeons routinely file appeals to carriers for payment and have complaints with the Department of Banking and Insurance. The Department of Banking and Insurance attempts to resolve these complaints.

Ms. Gonzalez reviewed the work slips provided by Dr. Petrone and conceded that she could not identify which doctors did the grafting in each of the five surgeries performed on the injured worker in this case. She also testified that Dr. Petrone did not add on any modifiers for the injured worker's bills. The respondent produced the case record reports for the five surgeries done on the injured worker in this case. These reports were dated and time stamped. These reports contain the list of the personnel in the operating theatre and a complete description of the work done by each doctor. Each report identifies one surgeon who did the debriding and the grafting.

The respondent recalled Dr. Marano to address the case record reports marked as R11. Dr. Marano testified that the nurses use the report system primarily to ensure correct counts in the OR. He also testified that the system limited the data that could be entered; specifically that only one surgeon's name could be entered unless two separate procedures occurred during the surgery.

The respondent produced Ms. Carol Emmons as its first lay witness. Ms. Emmons is a senior Coding and Reimbursement Specialist working for NJM. She is a professional coder, certified by the American Academy of Professional Coders. She was first certified in 1999. She had to pass a 5 hour licensing exam to qualify as a certified coder. She is required to obtain 36 continuing education credit hours every two years to maintain her license. Ms. Emmons testified that NJM uses the American Medical Association Continuing Procedural Terminology book as well as the CPT Assistant, a monthly newsletter as resources for their data system. She also uses the manual issued by the American Academy of Orthopedic Surgeons in her work. NJM also subscribes to the American Medical Association CPT Network which is an online information service. NJM also purchases Ingenix data. The staff at NJM includes a Medical Director and several nurses and case managers familiar with coding and the data available from the AMA, CMS and Ingenix. Ms. Emmons has written two articles on coding which have been published with the Coders' Professional Journal "The Cutting Edge". Ms. Emmons testified NJM uses two surgeons for peer review in their billing process.

Upon presentation of a surgical bill, the coder at NJM first insures that it is related to a workers' compensation claim. Then, the coder compares the bills to the operative notes. NJM will not pay on certain codes unless they receive documentation that the work was done. If a modifier is applied, the NJM coder will refer to the CMS guidelines to verify that the procedure warrants the modifier. CMS publishes a website that delineates what modifiers can be used in any given procedure. The American Medical Association sets the codes; CMS sets the rules for use of the primary codes and which modifiers can be attached. Ms. Emmons processed the surgical bills

sent to NJM for the 5 surgeries performed on the injured worker in this case. The operative reports for the December 27, 2004, and the January 3, 2005 op notes were dictated on March 14, 2005 by Dr. Sylvia Petrone. The operative note for January 10, 2005 was dictated on January 11, 2005 by Dr. Marano. The January 17, 2005 operative note was dictated on March 14, 2005 by Dr. Sylvia Petrone. The operative note from the January 20, 2005 procedure was dictated on January 26, 2005 by Dr. Marano. The HCFAs for these procedures were sent to NJM on March 23, 2005 with the operative notes and the Burn Surgeons letter on the use of the 62 modifier. The HCFAs were paid sometime around April 27, 2005. No discount for prompt payment was given. Ms. Emmons testified that she read the operative notes, reviewed the assigned CPT codes, verified that the centimeters referred to on the operative notes, corresponded to the centimeters referenced to in the HCFAs submitted by the Burn Surgeons. She testified that NJM had paid for co-surgeons on a prior burn case. In that case, NJM accepted the 62 modifier and paid 125% of the usual customary and reasonable amount for the procedure allocating 62 1/2 % to each surgeon. Ms. Emmons testified that with a surgeon and an assistant surgeon payment is made at 100% for the surgeon absent multiple procedures and the assistant surgeon is paid at 16%. Ingenix provided the database for the customary usual and reasonable fees.

There are two types of modifiers that can be attached to a procedure; informational modifiers (those that provide details about the procedure) and money modifiers (those which indicate that a percentage is applied to the fees set for the procedure). Both CMS and the AMA define the modifiers. These authorities advise which codes can be billed with another primary code

and/or which codes should be bundled. Ms. Emmons was not aware of any other authoritative source which allowed a different percentage to the 62 modifier. In regard to modifiers she testified that the 51 modifier is both an informational and a money modifier. It was not used in any bills for this injured worker. It indicates a multiple procedure occurred. The occurrence of a multiple procedure was verified through a manual review. Each code is assigned a relative value unit (RVU). The highest rated RVU becomes the primary procedure. The primary procedure is paid at 100% unless a 62 modifier is attached and then the procedure is paid at 125% of the usual customary and reasonable fee, divided between the surgeons.

Modifier 58 is an informational modifier. It indicates a staged procedure. Modifier 62 applies to co-surgeons which she described as two surgeons working on one procedure as equals performing the full work of the code. Modifier 22 is both a money modifier and an informational modifier. In this case the modifier 22 applied to the special splinting that had to be done for the injured worker.

Ms. Emmons testified further about the treatment represented by the codes. Code 15000 is a surgical preparation of the recipient site. Code 15001 is considered an add on code. The first 100 square centimeters of site preparation are included in code 15000 and then each additional 100 square centimeters known as a unit would be assigned code 15001. Each unit after the first unit would receive additional payment. Code 15100 is for split grafting for the trunk, arms or legs and includes the first 100 square centimeters. Code 15101 would be the add on code for additional units. Code 15120 is used for grafting delicate areas for face, genitalia and 15121 is

the add-on code for those procedures. Ms. Emmons testified that after her review the bill would be forwarded to her adjuster for payment. She acknowledged that she did allow the co-surgeon charge on the Reyes case, a case prior to the instant case. Ms. Emmons prepared a chart marked as R29 in evidence that demonstrated the steps she took to work out the appropriate charges for the work done on the injured worker , based on the codes used by the Burn Surgeons and the Ingenix value assigned as usual and customary for the code. On the HCFA prepared for the December 27, 2004 surgery the Burn Surgeons charged $7,000 for 14 units. If NJM had applied their UCR unit calculation the payment would have been $13,413.75. The respondent never pays more on a bill than the amount charged by the provider.

Ms. Emmons then testified that Ingenix data base is a charge base system. Information in the database reflects changes on the charges year by year. Fees go up and down. Ms. Emmons was aware of the letter sent to NJM by the Burn Surgeons concerning the use of co-surgeons. She testified about the EOB form sent to medical providers by NJM. This form utilizes explanation codes to demonstrate how payments were calculated. Ms. Emmons explained the EOB marked as R2 which showed the amounts approved for each code for each doctor on their bill. The first surgeon was paid 100% of the first procedure and 50% for the second procedure. The second surgeon's bill was denied. Next, the witness was asked to review a bill submitted by Dr. Oppenheim for work done on this injured worker. Dr. Oppenheim is an orthopedic surgeon who provided care to the worker on June 8, 2005. The procedures done by Dr. Oppenheim were billed with codes 15000, 15001, 15100 and 15101. Dr. Oppenheim grafted 418.5 square centimeters. In regard to the actual dollars paid to Dr. Oppenheim. Ms. Emmons testified that

Dr. Oppenheim received the same amount of reimbursement for the codes he used as did the Burn Surgeons when the Burn Surgeons did procedures under those codes. Medical providers are paid according to the codes which define the procedure. There is no differentiation in payment because of a particular specialty of a doctor.

Ms. Emmons testified as to the creation of a chart marked into evidence as R31 which contained billing information for the injured worker in this case and other NJM workers' compensation cases for which the Burn Surgeons provided service. In effect, this was a comparison of the codes used in the treatment of the worker in this case to other injured workers receiving similar treatment for similar injuries. Ms. Emmons brought the operative notes for these patients marked as R-32. She explained in detail the source of the data and formula calculations. The respondent then produced charted data on Medicaid co-surgeon cases for 2004/2005 (R-33) and Medicaid HMO 2004/2005 co-surgeon cases (R-34), automobile 2004/2005 co-surgeon cases (R-35) and 2004/2005 self-paid co-surgeon cases.

Ms. Emmons testified that the EOBs provided by the petitioner were incomplete. Modifiers and explanation codes were omitted. Ms. Emmons could not be certain how various carriers made payments to the burn surgeons. She noted percentages paid by Blue Cross/ Blue Shield as opposed to the percentages paid by NJM for the same code. Blue Cross /Blue Shield paid a higher percentage but on a lower fee schedule. So, for the code 15120 in 2004, NJM paid $1,826.88 and Blue Cross Shield paid $1,164. Under the Blue Cross/ Blue Shield payment schedule, each doctor was paid 62.5% of the charged amount.

Ms. Emmons reviewed the submission by petitioner for the cases which petitioner argued show payment for co-surgeons. She disputed Ms. Gonzalez' testimony. According to her review of the EOBs, other carriers denied payments for co-surgeons. Medicare reviewed payments for code 15120 and 15121 and paid significantly less but did allow a co-surgeon charge for these two codes only.

Ms. Emmons testified to other discrepancies in the Burn Surgeons billing system. In one case the Burn Surgeons charged for 16 units but produced records that indicated the payments made represented 34 units. Finally, Ms. Emmons testified regarding a chart she prepared marked as R-37 in evidence, this chart added the total charges for co-surgeons in 2004 and 2005. This came to $2,250,153.94. This was the total billed amount by the Burn Surgeons to all payers except for Medicaid and Medicare. The total reimbursement by various payers other than Medicaid and Medicare for 2004 and 2005 was $1,405,491.01. The ratio of payment to charges was 62.4%.

The total charges by the Burn Surgeons to Medicare and Medicaid HMO for 2004 and 2005 was $1,167,590.00. The total payment from Medicaid HMO was $209,342.42 or a ratio of 17.9%. Considering the reimbursement rate to Burn Surgeons by NJM alone, all of the bill co-surgeries for 2004 and 2005 totaled $388,251. Total payment by NJM was $280,319.61 a payment to charge ratio of 72.2%. On cross examination, Ms. Emmons testified that her review of the data did not include Blue Cross Blue Shield charges or payments.

She testified that NJM had recently created a network for participating physicians. A participating physician would receive either his billed amount less 20% or the UCR less a reduction of 25% whichever was the lesser amount. She testified to the specific patients she included in her chart (R-37). She did include one surgery done in 2006 because it did involve co-surgeons. She testified that in preparation of discovery she reviewed P-28 a letter to NJM from the AMA signed by a Ms. Walker which dealt with the status of the 51 modifier. She acknowledged that the 51 modifier can be used to indicate multiple medical procedures and that the physician determines the primary procedure. This determination must be consistent with the RVUs assigned to the procedure.

Ms. Emmons was asked about codes appearing on G. T.'s HCFAs, specifically code 15120 and code 15100. She indicated that she relied on Ingenix to supply the RVU (Relative Value Unit) to indicate which procedure was considered more complex. When asked to differentiate between the work done by the Burn Surgeons and the work done by Dr. Oppenheim, Ms. Emmons again testified that the code defined the work effort. The modifiers indicated the multiple procedures that occurred during the same operative procedure. Ms. Emmons noted that these procedures occurred during one anesthesia. In accord with the practice and workers' compensation court, Ms. Emmons returned for cross examination on September 7, 2010. At this hearing, Ms. Emmons testified to a revised version of a chart marked into evidence as R-39. The revised version was marked R-39A. Ms. Emmons revisited the calculation regarding payments made by Medicare and Medicaid/Medicaid HMO in response to billing by the Burn Surgeons. In this chart, considering only Medicare/Medicaid HMO, Medicare/Medicaid HMO

paid 17.9% of the charged amount. When included with the other carriers, the percentage paid rose to 47.4%.

On page one of R-39A Ms. Emmons testified that she removed the reference to the 2006 procedure with co-surgeons. On this chart, the total billed/total paid ratio was 62.7%. Ms. Emmons did not include calculations including Medicare and Blue Cross/Blue Shield.

Page 4 of R-39A showed the total billed/total paid by NJM to the Burn Surgeons ratio as 73.5%. Ms. Emmons was asked about NJM calculation of UCR and acknowledged that NJM used the data in 2004 and the 2005 physician's fee reference comprehensive fee report, published by Yale Wasserman. This report uses the Medicare relative value system (RVU).

According to this reference, the RVU for code 15100 is higher than the RVU for code 15120. Ms. Emmons testified that the UCR 15120 is usually higher than the UCR 15100. Ms. Emmons had no explanation of this other than these values were supplied by Ingenix and accepted by NJM. Ms. Emmons testified to minor corrections she made on her chart, deleting one procedure as it did not involve a co-surgeon and correcting an underpayment. In all, Ms. Emmons reviewed over 11,000 individual data entries in the chart marked as R-40. Petitioner brought 32 entries on this chart which they alleged Ms. Emmons made in error, 11 referenced PIP claims and the 23 entries remaining were explained by Ms. Emmons. She incorporated the corrections into the R-40 chart. She also compared payments made by NJM to payments by all other commercial carriers and calculated that NJM paid 17.2% more than the other carriers.

When Medicaid was included in this last calculation, NJM paid 55% more than the other carriers. When NJM and Medicaid were removed from all calculations, the Burn Surgeons received 60.7% of the billed charges. With Medicaid added, the percentage paid to Burn Surgeons was 44.3%. These additional calculations were added to R-39A.

At the conclusion of Ms. Emmon's testimony, petitioner sought leave to bring back Ms. Claribel Gonzalez for rebuttal testimony. I permitted this because the testimony of each was so technical that I thought it best to hear both witnesses as close in time as possible.

Ms. Gonzalez provided another set of charts as well as a "total" page marked into evidence as P-25. Ms. Gonzalez testified to the revisions that she made on her charts after Ms. Emmons testified. In some cases, Ms. Gonzalez pointed out that NJM's UCR is higher than what the Burn Surgeons calculated as UCR. She noted that NJM had paid the Burn Surgeons 62.5% of the billed amount for the Reyes case rather than the NJM UCR. 62.5% based on the Burn Surgeons UCR was less than 62.5% of the NJM UCR.

At one point, she testified that NJM paid 32.6% of the NJM UCR rather than the 100% noted by Ms. Emmons. However, the charged amount by the Burn Surgeons was $7,000; the NJM UCR was $21,462. NJM paid 100% of the Burn Surgeons billed amount. The 32.6% was the percentage of the $7,000 paid out of the $21,462 amount. She agreed with the underpayment corrected by Ms. Emmons and the other minor errors. According to her calculations, NJM should have paid $244,956.25 for code 15101 rather than $145,199.26 actually paid. In the first

calculation of total payments for NJM patients, Ms. Gonzalez testified that NJM paid 71.05% of the charged amount. Ms. Gonzalez pointed out that when a final payment was made on the G. T. account, NJM had paid 73.6% of the charged amount for the worker.

Ms. Gonzalez testified to the settlement achieved by the Burn Surgeons with Blue Cross/Blue Shield. It was her testimony that $100,000 from Blue Cross/Blue Shield was applied to various accounts but she could not identify the amounts applied to specific patients. Ms. Gonzalez testified about additions made to her spreadsheets referring to some PIP cases in which benefits had maxed out and Blue Cross/Blue Shield became a secondary carrier. The parties disputed the source and allocation of payments to patient H. V. Ms. Gonzalez also produced a spreadsheet marked as P-21F into evidence which she testified represented all workers' compensation cases compiled in her worksheet excluding NJM. According to her calculations, the Burn Surgeons was paid 82.5% by other workers' compensation carriers. In conclusion, on direct, Ms. Gonzalez stated that with her changes, NJM paid 71.05% of the charged amount but that in comparison with other carriers NJM paid only 2.2% more than other carriers not the 17.9% testified to by Ms. Emmons. Her next set of calculations, the total paid by all carriers excluding Blue Cross/Blue Shield, Medicaid, Medicare and NJM came to 84.2% of the charged amount which she also calculated came to 15.62% less than payments made by NJM. She did not produce the accounting tapes to justify her calculations until the next listing date.

On cross examination, Ms. Gonzalez reviewed the practice of adding modifiers to CPT codes. Modifier 59 notes a second procedure; primary codes are paid at 100% and second procedure

codes are reduced by 50%. Add on codes are not reduced by a modifier 59. Ms. Gonzalez testified that her employer was the St. Barnabas Hospital. Her office is located in the hospital on the second floor.

Ms. Gonzalez was asked to review P-18 and P-19 in evidence, the physician's reference guide for 2004 and 2005. She acknowledged that code 15100 had a higher total RVU than 15120 for those years. She also admitted that on the procedures for the worker in this case, code 15120 and 15121 were billed by each of the two surgeons for the first procedure and billed again by each of the surgeons on the second surgery. Code 15100 was billed on all five of G.T.'s surgeries.

She noted that she changed some of the entries on the chart to conform them with what she thought was the appropriate NJM UCR amount. These changes occurred in the data for the Lynch, Reyes and G.T. cases. She did not independently verify the UCR in effect for those respective dates. She was not aware that carriers and NJM in particular, routinely updated their database reflecting changes provided to them by Ingenix. Respondent's counsel identified other changes to the UCR made by Ms. Gonzalez on her chart which in turn reduced the percentage of charge/paid amount. She admitted she had no independent basis to change the UCR; she changed the numbers merely to conform. The changes without verification were repeated for other codes. Even with her calculations, Ms. Gonzalez admitted that NJM paid the Burn Surgeons 75.1% of their charged amounts for G.T. Ms. Gonzalez testified that the procedure listed as code 31600, a tracheotomy, should not be subject to multiple procedure

discounts of 50%. She argued that it was a stand alone procedure that required separate preparation. She learned this in her Burn education course at the hospital. For G.T., the Burn Surgeons billed $1,050 for the tracheotomy. NJM UCR code for this procedure was $1,500. For this procedure for G.T., NJM paid $750 or 50% of their UCR. Ms. Gonzalez testified that her chart marked P21C showed that NJM owed Burn Surgeons $13,985.26. Ms. Gonzalez admitted that the $3,985.26 amount was derived from the addition of the payment for the tracheotomy at 100% of UCR the balance would represent payment of 191.6% of the amount charged by the Burn Surgeons. At no time, according to Ms. Gonzalez did any carrier pay more than the amount billed. Burn Surgeons did negotiate with carriers and did accept less than the billed amount from other carriers. In reviewing the data, Ms. Gonzalez had to admit to accepting less than the other billed amounts from Coresource, Paradigm Health, Liberty Mutual (on more than 4 occasions) and Hartford. Ms. Gonzalez changed the data on her charts to reflect what payments would have been at 100% but acknowledged that the payments were a negotiated amount and that the application of the payment amount among the various accounts was not established by her.

One of the entries for S.R. on Ms. Gonzalez' chart referenced to payment of $2,687 which was the policy amount for Naughton Insurance. United HealthCare, a secondary payer on this account did not pay for the second surgery on that charge.

On payments for patient E.F. payment came not from the carrier but from an attorney, the proceeds from a third party recovery. Ms. Gonzalez included a reference to patient R.V. whose

bills were paid by the Carpenter's Health Fund. There were no correlating EOBs to explain the payments. Ms. Gonzalez testified that a negotiated settlement was reached but could not show precisely what payments were made or how they were applied. On patient E.F., GE Health rejected the second surgeon's bill. Ms. Gonzalez could not produce an EOB for patient D.D. or H.V. but did include it in her chart. Respondent's counsel pointed out that the chart showed a payment of $640 but the corresponding EOB showed the payment for that patient to be $197.25.

Ms. Gonzalez had difficulty explaining her characterizations of payment made to patient M.A. by GenQuest. She testified that two payments were made for this patient but could only produce one EOB for $1,058.68. Her explanation was that the payments were specially negotiated for this patient.

There was additional confusion about payments made for patient S.R. Ms. Gonzalez testified that each surgeon was paid $1,200 for code 15001 for date of service of July 21, 2005 but she could not show any supporting documentation.

Ms. Gonzalez did testify in looking at total charges paid including Blue Cross/Blue Shield that the Burn Surgeons accepted 65.7%. She had to admit that some of the entries on her chart should not have been included, specifically references to patients H.V. and D.D. She should have deleted not only the reference to Blue Cross/Blue Shield on her chart but also the amounts. As a result, all of her percentage calculations were in error. Finally, there was a

significant discrepancy concerning discovery given to respondent by petitioner. Pursuant to a request for further information from the Burn Surgeons in regard to payments for patient H.V., counsel for petitioner sent an email dated June 10, 2010 (R-44) that indicated that there were no EOBs for a portion of the bill paid by Blue Cross/Blue Shield. The additional money was blended into the global settlement reached between the Burn Surgeons and Blue Cross/Blue Shield.

The original documentation on this patient marked R-35 did not show additional inpatient services. Reference to inpatient services were deleted from the first documentation sent to NJM. However, there was no indication that the check for H.V. which was sent with the first documentation included any payment for the inpatient service. R-42 in evidence, an unexpurgated document shows the additional services which in turn corresponded to the appropriate payments made. This deletion by the petitioner manipulated the information and caused the appearance of a greater payment for the surgeon's services than was actually made.

Her chart did not reflect multiple procedure reductions. According to her the chart shows that the payment should be at 100% regardless of who does the work, secondary procedure reduction or modifier attached.

The respondent's second lay witness was Kim Zieglar. Ms. Zieglar is the Assistant Vice President for Medical Services in the NJM Company. She oversees medical utilization, medical bill

processing, physician credentialing and the software systems needed to carry out these tasks. She works with both workers' compensation and PIP.

Part of the utilization management includes surgical bill reviews. The utilization department looks at the proposed treatment against clinical evidence to be sure that it is appropriate for the injury and meets a level of evidence based necessity. Ms. Zieglar detailed the manner in which surgical bills are processed at NJM. When received, the surgical bill is identified using the surgical code range and all necessary identifying particulars are determined. The operative note must accompany the bill. Ms. Zieglar testified that the bill will be examined by a coder on staff who will compare the services rendered during the surgery to the codes on the HCFA to be sure that the codes used on the HCFA are accurate. The coder will examine the procedures and made a determination according to CPT guidelines to be the primary code.

In the case of co-surgeons, NJM will only process a payment claim if it has both bills from the surgeons. The coder also looks for any modifiers attached to the bill. Modifiers may affect payment. Ms. Zieglar testified that NJM uses UCR and then applies appropriate reductions. In her estimate, NJM processes approximately 4,000 surgical bills per year. Ms. Zieglar worked her way up the ranks at NJM starting in 1995 as a Case Manager and finally earning a promotion in 2010 to Assistant Vice President. Ms. Zieglar was Carol Emmons ' supervisor in 2004/2005 when the bills for G.T. came to NJM for processing. Ms. Zieglar testified that each coder did an analysis on codes submitted to insure accuracy. Code analysis includes identification of primary procedures.

Ms. Zieglar testified that NJM utilizes the resource based relative value scale (RBRVS) a system accepted and adopted by CMS, Medicare and Medicaid Services. This scale has been in use at NJM since 1994.

The RBRVS was developed at Harvard in 1985. It was adapted for use by Medicare/CMS in 1989. It is accepted and used by the American Medical Association. The RBRVS is composed of relative value units (RVU). There are three categories considered in establishing the total RVU. The first category is the physician's work effort, the second is the physician's expense component and the third is the malpractice component. The procedure with the highest RVU value becomes the primary code. Evaluating RVUs is the job of the American Medical Association, Relative Value Update Committee (RUC). This review is done annually. A total review of the entire scale is done by the AMA every five years.

Ms. Zieglar was provided P-23 and P-24 in evidence to examine. These submissions were publications by Ingenix and St. Anthony that reference only the physician's work effort and did not take into consideration components for practice expenses or malpractice insurance. NJM does not use this scale but relies on the more generally accepted RBRVS scale which does include both of these last two components.

Ms. Zieglar testified that CMS is the only entity that publishes the RBRVS scale and that it is well accepted and well recognized by both providers and the payer community.

Ms. Zieglar testified that NJM licensed a database from Ingenix. Specifically, the database license is the Prevailing Health Care Charge (PHCH). This data is used as a UCR by NJM. NJM receives updates from Ingenix twice yearly usually in January and July. This new data is embedded in the NJM system. The data supplied to NJM applies for the specific New Jersey area. When the updated disc arrives it is first tested by NJM and then implemented.

The data changes constantly. According to Ms. Zieglar the updates include the last 12 to 18 months of charged data. This data is plotted and then percentiles based upon these calculations are set. Ms. Zieglar stated that a bill presented in May might not be paid at the same amount in July because of the update of data. The date of service governs the application of the payment formula, not the date the bill was submitted for payment.

In 2004 and 2005 NJM called their system Legacy. In June/July of 2010, NJM upgraded their financial and medical bill payment system. Respondent's counsel directed Ms. Zieglar's attention to R-4, a package of materials for patient named Lynch. On this chart under scheduled amount is the UCR fee that was derived by using the PHCH database. This was supplied by Ingenix and used as the NJM UCR fee for this service. The Legacy system had editing and auditing capability. At NJM surgical coders always reviewed surgical bills. This system requires the entry of a code, the date of service, the provider and the geographic region. The data is entered; the system generates an EOB, discrepancies are kicked out of the

system and subject to manual review. If appropriate, the reviewing coder can override the system and arrange for payment. NJM is a managed care organization recognized by the State of New Jersey. According to Ms. Zieglar NJM had to apply to the Department of Banking and Insurance for this. NJM had to develop a Utility Management Policy, a peer review policy, a quality committee, a credentialing committee and an appeals process. There is a formal appeals process in place at NJM. The provider must put any disagreement in writing. NJM reviews the billing process to make sure there was no data entry error. The coder then reviews the disputed bill. If necessary, NJM will do a peer review to be sure that the code was correctly applied. The third level appeal according to Ms. Zieglar is in the Division of Workers' Compensation through the filing of a claim petition.

NJM has a panel of peer review doctors available but in a situation where a specialist is needed they will reach out to find an expert in the particular field needed.

On cross examination, Ms. Zieglar was asked to review R-41, the chart for Orville Lynch. She testified that in addition to CPT codes, each HCFA contains diagnostic codes. In Ms. Zieglar's opinion, responsibility for choosing the correct diagnostic codes and the correct CPT codes lies with the treating physician. Both are required before the bill can be processed by NJM. The billed amount on R-41 is the amount charged by the Burn Surgeons. The scheduled amount on Chart 41 is NJM UCR value. The approved amount, the amount paid by NJM to the provider is then calculated by the primary procedure, then considering any modifiers. If the 62 modifier is applied, the procedure is paid at 62.5%. There would be an additional reduction taken if

multiple procedures were performed. NJM never pays more to a provider than the provider charges.

On the Lynch bill, the 15120 code was considered primary. The charge was $2,400. There was a 62 modifier which reduced the charged amount to 62.5% or $1,500. Next on the Lynch bill, code 15100 was charged at $2,055 and paid pursuant to a 62 modifier $1,284.38. Four other charges on that HCFA had the additional multiple procedure reduction.

Ms. Zieglar admitted that the system caused a denial for one of the charges on the Lynch bill. The system had noted that there was already another bill for the same date of service and for the same code for that patient. The system read this as a duplicate. A manual review corrected this and allowed a payment of 62.5%.

Ms. Zieglar testified to other codes used by carriers to shorthand explanations to providers about payment. These codes are found on the back of the HCFA 1500 form. These codes help a provider understand payments made. Ms. Zieglar acknowledged that there might have been in overpayment in the Lynch case upon reviewing the RVUs for codes 15120 and 15100. The RVU for code 15120 is 21.69. RVU for code 15100 is 22.80. In her opinion, this would cause a coder to rank the 15100 procedure as primary.

In conclusion, Ms. Zieglar testified that NJM does not have a written policy in place concerning the use of the Ingenix data for UCR. Ms. Zieglar could not compare the Saint Anthony system (which only considers the physicians work) to the database used by NJM.

Petitioner produced Sherrel Modell as its expert witness. Ms. Modell has an undergraduate degree in Nursing from Boston University and a Master's degree in psychiatric nursing from Boston University. She also has an MBA in Marketing and Finance from Columbia University School of Business. Ms. Modell has worked at the Boston State Hospital with geriatric patients. She taught at Whidden Memorial Hospital School of Nursing. She worked in nursing at Florham Mental Health Care Center and as a nurse she had to do patient charting. In 1978, Ms. Modell became a pharmaceutical sales representative for the McNeil Pharmaceutical Company. She left this job to get her Master's degree. After this she worked at a pharmaceutical ad agency as an account executive. She did not like this work and took a job with Empire Blue Cross/Blue Shield. At Empire, her job was to develop programs on health care cost effectiveness. She stayed with Empire Health for five years. She next took a position at Ernst and Young. At Ernst and Young Ms. Modell did diagnosis related group (DRG) code review. After Ernst and Young, Ms. Modell worked at the New York Eye and Ear Infirmary as a Director of Quality and Utilization Management. After New York Eye and Ear, Ms. Modell went to UMDNJ as Director of Case Management. After UMDNJ, Ms. Modell took a position with Health/ROI, a firm which she described does documentation, support, revenue recovery, DRG review and regulatory appeals. At present, Ms. Modell's firm does (APC) Ambulatory Payment Classification review. The firm goes into hospitals and reviews Medicare payment data with an eye to identifying

missing CPT codes. She described training a doctor to note casual questions as taking a social history and then increasing the billable amount for this interaction resulting in a different, higher reimbursement for the doctor.

Ms. Modell became a Certified Coder about 18 months before she testified. She has testified on one prior case concerning coding and then one arbitration hearing concerning documentation.

During voir dire Ms. Modell admitted that other than some per diem work in graduate school, she has not worked as a nurse since 1978. She has never testified before in New Jersey. She is not a member of the American Burn Association. She has never been employed as a Coder but she did work with coding at New York Eye and Ear and at UMDNJ. She admitted that her firm recovered 1.8 million dollars in 2009 over and above what Medicare had paid her clients. Her firm was paid for this recovery on a contingent fee agreement.

In training personnel at Health/ROI, Ms. Modell did not teach the Coders to consider RVUs or RBRVS. She did not use any nationally recognized coding program in developing her training programs at Health/ROI. Ms. Modell's primary experience was in hospital billing. She reviewed hospital billing and then her firm would take a percentage of any increase retrieved. Ms. Modell did not prepare an initial report; her first report was a rebuttal to the report of the respondent's witness, Dr. Lawrence Spitz. She testified that she was familiar with UCR and Ingenix. She was familiar with Medicare but could not testify about how Medicare calculates its payments, even though Medicare was the majority of her revenue recovery attention. Ms.

Modell detailed the review of the material that she made before her testimony. In regard to modifiers, Ms. Modell testified that it was crucial for a medical provider to correctly use the appropriate modifier. At first she testified that no modifier could be attached to a primary procedure but then she conceded that modifier 62 could be attached to a primary procedure to indicate the use of a "co-surgeon".

With modifier 51, Ms. Modell testified that Medicare no longer uses it as it served no useful purpose. The need for modifier 51 was superseded by payment programs that carriers use. These programs select the procedures with the highest RBRVU as their primary procedure. Ms. Modell testified that the function of a primary surgeon and an assistant surgeon differs from the functions of co-surgeons in that the assistant surgeon takes direction from the primary surgeon and co-surgeons have equal responsibilities and collaborate on the surgery.

In her opinion, it was appropriate to bill as co-surgeons because "the burn surgeons were doing things that were very different from the usual surgery". According to Ms. Modell, the burn surgeons were trying to do 2 to 2.5 times as much in one surgical session as could be done with one surgeon. She noted that the burn surgeons were dealing with critically ill patients. Ms. Modell did admit that she had no experience with burn surgery other than reading medical records. In her opinion, use of co-surgeons would reduce the length of stay in the hospital.

Ms. Modell was asked about how a primary procedure was determined. She testified that the most difficult, the most time consuming, the most technically challenging was given the highest

RBRVU. In reviewing G.T.'s case, Ms. Modell was of the opinion that code 15120 should be marked as the primary procedure. In her opinion the techniques needed to avoid scarring on the facial areas and other delicate areas were handled differently from the other grafting surgeries. On cross-examination, Ms. Modell admitted that she reviewed G.T.'s operative notes. She conceded that CPT codes and modifiers as described by Dr. Spitz were appropriate. She accepted that the medical providers used the HCFA and that CPT codes are periodically updated by the AMA in consultation with the appropriate sub specialty groups. The American Burn Association participates in and contributes to the development of national standards for CPT codes and RVUs.

She accepted that physicians can use modifiers for certain procedure codes to indicate a procedure performed was altered by specific circumstances but the procedure does not change in its definition or code. She also accepted that CMS defines the meaning of CPT codes and modifiers and how they are applied to reimbursement and that CPT codes and modifiers have usual and customary and generally accepted meanings.

She acknowledged that Dr. Spitz used national standards for his definition for co-surgery and reimbursement.

She was not familiar with the American Burn Association nor did she know if the American Burn Association was a resource for setting standards for coding for burn centers. She was given the American Burn Association primer for review in preparation for her testimony.

Ms. Modell was not aware of whether or not United Health Care follows Medicare rules regarding modifier 62. She did not know the ranking of United Health Care in size. In her report, Ms. Modell stated that there was no evidence to indicate that NJM has a policy to follow Medicare rules. She had not reviewed R-16, a pre-certification form that indicates that NJM follows CMS rules for co-surgeons.

After reviewing a hypothetical by respondent's counsel, Ms. Modell admitted that NJM did have payment policies in place. She testified that she was not given information about NJM's computer edited based policies. She did not read the testimony of Ms. Kim Zieglar, the source of the facts for respondent's counsels hypothetical.

Ms. Modell was asked to assume that:

1. The codes used for procedures on Mr. T were eligible for 62 modifiers and that with documentation, under CMS standards, NJM would have paid 62.5% of UCR.
2. That NJM reserves the right in each individual case to reimburse co-surgeons for procedures that failed to meet the co-surgeon criteria, and;
3. That NJM did reimburse the two surgeons at 62.5% of UCR to each rather than 100% of UCR to one surgeon alone.

Ms. Modell was then asked if it were her position that no rules were in use by NJM. She responded that it was her position that every carrier has the right to modify payment based on the documentation it sees. She did admit that under CMS and AMA rules that the codes in G.T.'s case were not eligible for co-surgeon billing.

She also admitted that Dr. Spitz, recitation of the CMS requirements for documentation correctly cites the CMS and AMA rules.

Ms. Modell agreed that the CMS and ABA requires separate operative reports from each surgeon. Respondent's counsel provided R-41 to Ms. Modell for her review. These were reports related to patient Lynch. In this package of records, Dr. Marano and Dr. Petrone each dictated an operative note. In her opinion, the operative note prepared by Dr. Marano was not sufficiently detailed. However, the rules for documentation in 2004 were less rigid according to Ms. Modell.

Ms. Modell could not cite the CMS rule requiring a physician to specifically document what he or she did. Ms. Modell also testified that it would be reasonable to expect operative reports from each surgeon if they were both in the operating room and taking part in the surgery. She could not explain why Dr. Petrone and Dr. Marano did separate operative notes for the June 17, 2004 surgery on Mr. Orville Lynch but not for the G.T's surgeries in 2004/2005. The rule for this requirement of separate reports existed but was not followed by Burn Surgeons in the G.T. case. Ms. DeBellis, respondent's counsel, prepared a hypothetical question based on Dr. Marano's testimony for Ms. Modell's consideration. The hypothetical dealt with the activities of the Burn Surgeons as two surgeons worked together in the operating theatre. Having considered this hypothetical, Ms. Modell offered the opinion that the circumstances described by Dr. Marano would warrant consideration as co-surgery. She could not cite any recognized standards to support her position. She based her opinion on her clinical judgment and gave an

additional opinion that contrary to the AMA, CMS and ABA protocols, two operative reports in the G.T. surgery would be unnecessary and redundant. Ms. Modell testified that she relied on Ms. Gonzalez work in preparing attachment C to her report and did not do any independent verification of the accuracy of attachment C. Based on attachment C of her report, Ms. Modell testified that each doctor should receive 87% of UCR for their work as co-surgeon. She admitted that that percentage was not set by the AMA, CMS or ABA and the only basis for demanding the 87% arose from calculations on attachment C as prepared by the witness. Ms. Modell was not aware that some of the payments on attachment C were the result of negotiation by Ms. Gonzalez. Ms. Modell agreed that it is not a standard practice to negotiate on a case by case basis or reimbursement from medical payers.

In preparing her for her testimony, Ms. Modell did not review any Medicare bills. She testified that despite her statement in her report that, "the billing for surgery performed on Mr. T on December 27, 2004 illustrates the surgeon's understanding of how and when to apply modifier 62". She now acknowledged that Dr. Marano had no knowledge of billing procedures. She was not aware that the Burn Surgeons prepared HCFAs without reference to an operative note but instead relied on a worksheet prepared by a surgeon who may not have even been present in the operating room. She also acknowledged that many of the billing practices of the Burn Surgeons would not be sanctioned by the AMA, ABA or CMS. In an article written by Ms. Modell, she advocated that proper payment require proper coding which requires proper documentation. Based on her review of the December 27, 2004 operative note, she had no ability to testify to the work done by Dr. Marano as the report only documents the work of Dr.

Petrone. She could not justify the use of modifier 62 and conceded that although the actual guideline should not be predominant, individual circumstances should be considered. Ms. Modell was of the opinion that during the surgery both doctors grafted and did medical management at the same times, specifically one surgeon doing the excision of skin, the other doing the grafting, but had to concede that this was not the case. Ms. Modell testified that regardless of skill or experience, the standards of reimbursement requires that the doctor be paid at the amount attributed to the code. Although there are few surgeons in New Jersey who do burn surgery, there are other doctors, orthopedists and plastics surgeons, who do excision and grafting and utilize the same codes as the Burn Surgeons. They would receive the same rate of payment. Ms. Modell reviewed the rules of the anesthesiologists, nurses and residents in the OR. She was then asked about the findings in her report. In her chart on page nine of her March 29, 2010 report, Ms. Modell agreed that the code chosen by NJM as a primary code was accurately identified. In her testimony she stated that this was a mistake. Ms. Modell made the argument that some consideration should be made for fairness although she conceded this was not a coding reason. She asserted that CMS did not allow for co-surgeons for codes 15000 (site prep) and 15100 (grafting) because in her opinion the bulk of Medicare burn cases are small cases involving small burn areas. Ms. Modell knew that the Burn Surgeons charge the same amount regardless of the payer. She did not know what standard CMS used to determine primary codes. She expected that billing and coding errors would be caught by the payer's software review which she felt was less likely to allow human error.

Ms. Modell testified about modifiers 51 and 59 and the difference between in network and out of network payments. Although Ms. Modell stated that she would like to see charged fees used as a basis for UCR determination, she recognizes and accepts the decision by the Department of Banking and Insurance to use paid fees. She was not familiar with the cases in New Jersey on this point. The procedure with the highest weight or value should be the most highly reimbursed. She admitted that the RBRVS serves as a model and is the most widely used system even by non-governmental payers. However, in preparing her reports for testimony as petitioner's expert, Ms. Modell used codes not in use in 2004 and not billed in G.T.'s case. These codes came into use in 2008 and varied in value compared to the codes used for Mr. T's treatment in 2004. She could not explain why she did not use 2004 data. She also had to admit to errors in the preparation of the chart she created to show which procedures should be counted as primary. She had to concede that in 2004 NJM was correct in selecting code 15100 as the primary code as at that time it had a higher RBRVS than code 15120. She could not explain why the RBRVS for 15120 was higher in 2008.

The Respondent produced Dr. Lawrence Spitz. Dr. Spitz is an internist who is board certified in Quality Assurance and Utilization. He has a Masters in Business Administration from the Wharton School of Business.

Dr. Spitz has practiced as an internist since 1983. At the time of his testimony, Dr. Spitz was a Clinical Associate of the Medical School of the University of Pennsylvania. He became board certified in Quality Assurance and Utilization in 1981. To quality for this board in 1981 a doctor

had to be board certified in another field of medicine and had to have two years' experience in hospital based Quality Assurance and Utilization Review.

Dr. Spitz defined Quality Assurance and Utilization Review as the process by which care to patients is reviewed to determine if it meets national standards. Dr. Spitz was familiar with coding issues and usual, customary and reasonable standards. He has testified as an expert in internal medicine and Quality Assurance and Utilization Review. After voir dire, Dr. Spitz was admitted as an expert in internal medicine and quality assurance and utilization.

Dr. Spitz testified about the development of the CPT code by the American Medical Association. The codes are regularly reviewed. As the largest payer in this country, CMS/Medicare works with the American Medical Association and other health organizations to create a rational and fair payment system. Each of the CPT codes has certain specific uses and definitions that are universally accepted. Dr. Spitz described the three components of the resource based relative value scale, the work effort by the physician, the practice expense and the malpractice risk. Sub specialty practices are not given higher reimbursement for a procedure. The American Burn Association participates in the process of establishing values for their pertinent codes. Dr. Spitz testified that the HCFA is a single uniform form for billing and is almost universally accepted in the United States. Dr. Spitz described bundling and unbundling. When a medical procedure is comprised of component procedures, the individual procedures cannot be individually billed. Dr. Spitz testified that CMS determines whether a code is eligible for a modifier and that this

determination is published in the Federal Register under policy payment indicators. The definitions of modifiers are also found in the CPT manual.

Dr. Spitz was asked about the 62 modifier and the definition of co-surgeons. He quoted the CPT Manual "it applies to two surgeons, not three because that would be team surgery, but two surgeons. And what it says is that it defines the 62 modifier as 'when two surgeons work together as primary surgeons performing distinct parts of a procedure, each surgeon should report his/her distinct separate work by adding modifier 62 to the procedure and any associated add on codes for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code.

Dr. Spitz testified that if one surgeon worked on the right leg and the other on the left arm and if they only reported on their own separate work then it might qualify for a 62 modifier. However, he stated that it was not possible for two surgeons to show distinct work on the same part of the body during the single procedure.

Dr. Spitz gave an example of co-surgery in which a general surgeon opens the abdomen and then a vascular surgeon comes into the procedure and accomplishes his particular task.

Dr. Spitz referred to the policy payment indicators to confirm that the only codes in G.T's treatment plan eligible for co-surgeons was the procedure designated by code 15121. The

other grafting codes used in G.T's care were not eligible for co-surgeons. The surgeons must establish the medical necessity for two surgeons in the 15121 procedure.

Dr. Spitz testified that the burn surgeons are paid based on the total area of the graft site. The grafting code and the add on code for that code insures that for more extensively burned patients there is a greater payment. Grafting is precise work and calls for careful measurements and documentation. The American Burn Association Primer for coding and reimbursement contains the detailed examples and description of how to code various burn procedures. Dr. Spitz did not have an ABA Primer at the time he prepared his initial report. Thereafter he did review the 2004, 2005 and 2006 Primers. He stated that he found no material difference in these Primers.

Dr. Spitz testified that CMS takes the codes and modifiers created by the American Medical Association and applies a regional factor and then the payers simply do the arithmetic. According to Dr. Spitz, coding cannot be delegated to a clerk, the surgeon is responsible for reporting his/her work and must be sure that it is correctly coded.

In regard to co-surgeons, Dr. Spitz was clear that co-surgeons performed distinct parts of the procedures personally and each surgeon must personally write their own operative report.

Dr. Spitz referred to the American Burn Association 2005 Primer to discuss the use of an assistant surgeon. In his opinion, a surgeon, who during surgery monitors anesthesia, blood

pressure and observes the patient, may not even qualify as an assistant surgeon. Dr. Spitz quoted from the American Burn Association Primer that "many payers, including Medicare allow a total of 125% of the allowable fee for the definitive procedure. Payment is divided between the two surgeons, 62.5% of the total allowable for each surgeon. A claim is payable if current codes correctly reported are used.

All codes must be supported by backup documentation.

The surgeon must also rank procedures. Primary procedures are paid at 100% of the applicable UCR. Secondary procedures are reimbursed at 50%. Add-on codes are already reduced for payment and are not reduced further. According to Dr. Spitz the RBRVS is the key to determining which procedure is primary. Most software programs used by payers rank the procedures by the highest RBRVS regardless of the order in which they were submitted on HCFA. Dr. Spitz used a specific example in which he demonstrated that in one procedure using both code 15100 and code 15121 that code 15100 was the major procedure as it had a RBRVS of 22.94 and the 15120 code had a comparable RBRVS value of 21.73. Dr. Spitz also addressed the issue of when the provider's bills are less than the allowable amount. In that situation, the billed amount is paid.

In specifically addressing the issue in regard to G.T's treatment, Dr. Spitz testified that the letter sent out to NJM by the Burn Surgeons did not constitute a letter of medical necessity. He characterized it as a general statement about burns and coding. Any medical provider in the

geographic area who uses the codes normally used by the Burn Surgeons receives the same reimbursement. When the reimbursement structure was created, it took into account all burn burgeons with differing levels of experience and expertise.

When asked if the payments made to the Burn Surgeons met UCR, Dr. Spitz opined that the payments not only met but they far exceeded UCR. In response to the hypothetical marked as R-59, he testified that " if one defines UCR as the weighted mix of all the different payers, in other words, for all of the relevant codes, you see how much each of the various categories of payers make and you weight them by the number of times they made those payments, and then you compare them to what NJM paid, NJM's payments far exceeded with respect to UCR almost 1 and ½ times more than the other mix of payers paid, non NJM mix of payers paid".

The difference for non NJM payments Burn Surgeons was 43.3% compared to 73.5% as paid by NJM.

Dr. Spitz was of the opinion that NJM appropriately met its obligation to reimburse the Burn Surgeons for the surgical services rendered to G.T. In his opinion, NJM paid UCR. The Burn Surgeons asked NJM to waive the fact that the codes were not eligible for co-surgery and to pay more than 125% of the allowance for co-surgery. NJM paid more at 125% then would routinely be allowed by many payers.

Dr. Spitz took exception to the Burn Surgeons claim that these surgeries performed by Burn Surgeons are more complex. He testified that the large grafting procedures have add-on codes to cover the additional grafting work and to take into consideration the additional complexity.

In regard to the reduction of operating time and reduction of risk and stress, Dr. Spitz testified that if the presence of a second surgeon was required it would have been recognized by the American Burn Association and there would be a modifier to attach to the code to allow for payment for this additional surgeon. The additional work in the surgery is paid for by the reimbursement for the add-on codes. Dr. Spitz gave the opinion that the work done by the Burn Surgeons on G.T. did not meet the reporting requirements set forth by the American Medical Association and the American Burn Association. The Burn Surgeons did not meet the standard accepted by CMS, AMA and ABA in regard to billing or the attachment of modifiers. In his opinion, the decision by NJM to pay a co-surgery rate or a 125% was permissible even though it was more than UCR would have allowed.

On cross-examination, Dr. Spitz reviewed the resource base relative value scale and the relative value units. He acknowledged that he joined the American Burn Association after writing his first report for this case. He testified that he did this so that he could have access to ABA materials.

Dr. Spitz reviewed payments made by other carriers and acknowledged that some did pay a co-surgeon allowance. Others did not and only pay 100% of the primary surgeon's charge. Others

paid an amount in between and that some of the payments were made in satisfaction of a settlement pursuant to negotiation. Dr. Spitz acknowledged that CMS in consults with the AMA and subspecialties societies define the usage of modifiers. The commercial carriers have, for the most part, adopted these guidelines. The guidelines are only binding on payments for care to Medicare beneficiaries. The guidelines are not binding on the commercial carriers. Although Dr. Spitz has never known burn surgery, he did know to go to the ABA Primer for procedure definitions and examples. He again stated that the ABA is aware of the work required in these surgeries and has made appropriate allowance for reimbursement.

Dr. Spitz was asked to look at the operative note for G.T's surgery on January 3, 2005. In his opinion, the operative note sufficiently described the work by Dr. Petrone but did not describe the work done by Dr. Marano. It was not possible to tell which surgeon grafted which area. According to Dr. Spitz, it was impossible to tell what distinct part of the procedure each of the two surgeons did. He accepted that each doctor supervised the anesthesia and were involved in the meshing of the autograft. He could not tell which surgeon was primary and believed that one was primary and one acted as an assistant surgeon. He conceded in the situation where one surgeon worked on the arm and one surgeon on the leg each doing their own procedure, the 59 modifier could be used to indicate separate procedures and each could report and bill for the square centimeters each surgeon personally did.

Dr. Spitz was asked about the American Burn Association White Paper and he testified that the White Paper primarily dealt with the use of skin substitutes and the information necessary to

justify payment for the use of skin substitutes. He noted that the Burn Surgeons did not use skin substitutes and the issues in the White Paper did not pertain to the issues in this case.

Dr. Spitz did agree that it was in the discretion of the surgeon to decide whether two surgeons should operate on a patient at once.

Dr. Spitz was again asked on cross-examination about other non-burn surgeries that use the grafting codes. He testified that the development of the RBRVS takes into account all types of patients. He acknowledged that Blue Cross/Blue Shield pays for co-surgeons at 150% of what is a much reduced fee. Dr. Spitz was also asked about the use of Ingenix data base by NJM. He conceded that NJM used a fee schedule different from that used by the Medicare fee schedule. He testified that NJM made a policy decision to manually override their system to allow for payment in this case at 125%; 62.5% to each surgeon. Dr. Spitz confirmed that the RVUS as determined by Ingenix for procedures in 2004 and 2005 were identical to the RVUS valued by Medicare. Dr. Spitz reiterated that the codes determine which procedures are eligible for payment for co-surgeons and which for assistant surgeons.

Dr. Spitz reviewed the practice of unbundling again in which he described it as the separate billing of a code which is a component of a single comprehensive code. He noted that CMS publishes edits to its system annually in the CFR. Dr. Spitz was asked if only one surgeon had been used in the G.T. surgery would G.T. have had to undergo more surgeries. He felt that this scenario was speculative but that increasing the number of procedures would in fact increase

overall expense. Dr. Spitz testified that there are facility RVUS and non-facility RVUS. Procedures done in a doctor's office would be considered a non-facility and a doctor would be given a higher reimbursement because he bore the cost of staff and overhead. Procedures done in a hospital use the facility RVUs as the hospital picks up the overhead cost and bills for them in a separate technical fee. Each year Medicare reviews the practice expenses and can make changes to the practice expense component of that year's RVU values. All of G.T.'s surgeries were performed in a facility, St. Barnabas Hospital.

Dr. Spitz finished his testimony with reference to facility and non-facility RVUs. He noted that NJM elected to use a non-facility RVU data base from Ingenix and that non-facility reimbursements are higher because of the increased payments for practice expense. He concluded his testimony by giving his opinion that the CPT coding system is a just and fair means by which to compensate burn surgeons. He reviewed the American Burn Association Primers, the American Burn Association White Paper and online resources and did not find even a suggestion from these sources that the present system of compensation was unfair or unjust to burn surgeons. He noted that it was the responsibility of the individual provider to conform their billing to the standards set by the codes.

I have had the benefit of testimony from lay witnesses and experts. I have had the opportunity to hear from lay witnesses were expert in coding and two experts who have experience with coding. This was a difficult case to try. In order to prosecute the claim, the petitioner must show that that the payments made by NJM did not meet usual, customary and reasonable rates. The petitioner must demonstrate that other payers in the same geographic area paid

more for the same medical treatment as rendered to the worker in this case. Comparison has to be made among similar payments for similar codes. The petitioner produced HCFAs and EOBs for a number of patients who received surgery under the same codes used for G. T., the injured worker in this case. The data from these documents were transferred to charts for testimony. In this particular case, petitioner argues that the comparison cannot be made with any other medical providers because the Burn Surgeons are the almost exclusive provider of burn care in northern New Jersey. Billing is geographically sensitive. Reimbursement for services provided can vary depending on geographic location. Thus, payment for these codes in northern New Jersey might exceed the reimbursement given in Alabama or be less than reimbursement given in New York. The petitioner argues that the only basis for their proofs lies within their practice. If this were a case that dealt with orthopedic medicine, comparisons could be made with the amounts paid to other orthopedists in the same geographic area.

The petitioner also argues that the only payments that should be considered are those payments made by other commercial carriers and that payments made by Medicare, Medicare HMO, Medicaid, and Blue Cross / Blue Shield should be disregarded. Under our statute, the respondent is directed to pay fees that are reasonable, usual and prevailing in the same community for similar surgeons' services. There is no fee schedule in workers' compensation. I have reviewed Coalition for Quality Healthcare vs New Jersey Department of Banking and Insurance, 358 N. J. Super. 123 (App.Div. 2003). In this case, the court determined that carriers under PIP have an obligation to make payment based upon fees that are reasonable and prevailing on a regional basis. The appellate court held that paid fees were a more accurate

measure of "reasonable and prevailing fees". I adopt the findings of the appellate court in this case and I will apply the determination to consider paid fees rather than charged fees to this case. So far as this is applicable to workers' compensation, I accept that it is appropriate to use paid fees rather than billed fees to make a determination as to the usual and prevailing fees in billing. I accept that there is a balancing act between the attempts to contain costs while providing for a fair level of reimbursement for services rendered. In Coalition, the Court held that the "market payments" included those made by "government programs, participating provider agreements and other contractual arrangements between physicians and health care plans." I accept this holding as reasonable as well.

In this case, the parties have agreed to stipulate to the use of the Ingenix database. This is a database which uses paid fees to determine UCR and is used by both the Burns Surgeons and NJM.

There is a system in place created by the American Medical Association after research completed at Harvard which assigns CPT codes to all medical procedures currently done in this country. The study evaluated the work done under each code. These codes are regularly reviewed. The largest payer in this country CMS, has adopted these codes as part of its payment system. CMS has also created modifiers which accompany the codes. The modifiers can indicate when additional reimbursement is to be paid or can be informational about the procedure done. The codes and modifiers have been universally adopted. The use of HCFAs and EOBs are commonplace throughout the medical billing industry.

After a code is then assigned, with or without a modifier, the value of the code is determined through the resource-based relative value scale. This scale takes into consideration the work effort by the physician, the practice expense and the malpractice risk. Since each code represents a specific task done in the procedure, there is no sub specialty allowance. It is irrelevant whether the physician doing the procedure is a burn surgeon or a plastic surgeon or an orthopedic surgeon. It is irrelevant whether the physician is a novice at the procedure or is an expert of 30 years. All of these contingencies were considered when the codes were created. The physician is paid for the work of the code. Additional reimbursement is available to the physician through modifiers and add-on codes.

The American Medical Association publishes the CPT manual and other reports to help physicians determine the appropriate codes. The American Burn Association publishes annual primers to assist a physician in determining appropriate codes. These manuals include detailed examples and descriptions of how codes are to be applied. The data in these manuals are constantly under review. Updates are routinely published.

In addition, the values assigned to the codes are routinely updated. Each component of the resource-based relative value scale is given a value. This is referred to as a relative value unit (RVU). The three components are the physician's work, the practice expense and the malpractice allowance. These three components are added up to determine the total value of the code. The procedure with the highest RVU total becomes the primary procedure. It is

accepted by CMS that primary procedures are paid 100% and that secondary procedures are paid to 50%.

New Jersey Manufacturers Insurance Company uses the Ingenix database. It also uses and relies on current CPT and CMS guidelines. I find that the system presently used by NJM as provided by Ingenix fairly reflects UCR. I accept the process used by NJM as reasonable. The description of the process for bill payment as testified to by Ms. Emmons and by Ms. Zieglar appears to conform to the AMA CPT codes and the CMS guidelines.

The petitioner argues first that NJM's rejection of the petitioner's use of modifier 62 on the G.T. surgeries was in error. The petitioner argues that the 62 modifier indicating performance of co-surgery should be accepted and that each surgeon should be paid in full by NJM. The petitioner relies on the testimony of Dr. Marano to establish this authority for co-surgery.

I find that Dr. Marano's testimony about the definition of co-surgery does not meet any of the accepted definitions of co-surgery. I find that the accurate definition of co-surgeons is the one set forth by the American Medical Association and testified to by Dr. Spitz. Co-surgeons are two surgeons who work together as primary surgeons performing distinct parts of the procedure. The description given by Dr. Marano of the work done by the Burns surgeons on G.T. simply does not meet this definition. Dr. Marano describes the surgery in which one surgeon actively works and the other observes. Dr. Marano also argues that as a physician, he determined that it was in the patient's best interest to have two burn surgeons in the operating theater. It may

very well be the practice of the Burn Surgeons to have two surgeons in the operating theater for these procedures; however this practice is not recognized by the American Burn Association. I find that if two surgeons were necessary for the procedures described in codes 15000, 15001, 15100 or 15101 then CMS would have permitted appropriate modifiers. Dr. Marano could not tell which excisions he had performed and which excisions had been done by Dr. Petrone in several of the surgeries. Although he felt it was important to have co-surgeons or two surgeons in the room, he could not cite any protocols or policies from the American Burn Association that supported his opinion nor could he cite any Medicare guidelines for the use of co-surgeons. I find that the definition used by Dr. Marano to describe co-surgeons is not the definition as outlined by CMS and the American Burn Association. I find that the description given by Dr. Marano does not describe independent work of two surgeons but rather is more closely similar to the work of a primary surgeon and an assistant surgeon. Dr. Marano could not identify the total amount of grafting done by either of the doctors in these co-surgeries. Only one surgeon either did site preparation or grafting at a time; the second surgeon did not work on a separate area therefore reducing the total amount of time needed for surgery. Accordingly, I find that there is no basis to establish that these "co-surgeries" shortened the surgical procedures for the worker. I find that it was inappropriate for both doctors in these surgeries to each bill for the total amount of excision and grafting. It is clear that each doctor did some part of the whole. However, as each one did excision or grafting they acted as a primary surgeon not as a co-surgeon.

I find that Dr. Marano had no experience in billing and could not testify confidently about procedures done in the Burn Surgeon's office. He was aware of the letter (P-3) sent out by the Burn Surgeons. I find that this letter was an informational document and did not constitute a letter of necessity. I find that the Burn Surgeons of St. Barnabas had no basis for the request made in this letter. Their request for consideration for an increase in payment for co-surgery on the codes other than 15120 and 15121 would not have been allowed by the ABA, the AMA, CMS or any credible authority.

In trying these cases it is helpful to have witnesses familiar with coding and billing processes. Dr. Marano was a necessary witness in this case as there was a question as to the work done in the surgery. In those cases in which the dispute is over payment only and not whether the procedures were completed or the manner in which the procedures were completed I find that it is unnecessary to have the doctor testify. The petitioner must produce a party responsible for the data and an expert who can interpret it if necessary.

I find further that the doctors at the Burn Surgeons of St. Barnabas did not use the appropriate reporting requirements. All of the experts acknowledged that separate operative notes should be done by each surgeon participating in the surgery. This was not done.

I considered the testimony of Claribel Gonzalez. Ms. Gonzalez was the billing supervisor for the Burn Surgeons at St. Barnabas Hospital. I considered the data that she provided however I find that her date was unreliable and unfocused. She could not identify the work done by each

surgeon on each of the surgeries. She could not explain the application of settlement moneys against the bills that she testified to on direct. There were several errors in her spreadsheet where she included payments from PIP carriers and third party settlements that should not have been included in the data sheet. According to her testimony, Ms. Gonzalez believed that the mere fact that any time two surgeons participated in a surgery, the bill should be marked with a 62 modifier. She also testified that it was a clerk who added the modifier. I find that the appropriate party to determine whether or not a modifier should be used is the physician. Ms. Gonzalez had to concede that on several occasions that when the Burn Surgeons billed for code 15001 they received significantly less from other carriers. NJM routinely paid 63% of the amount charged whereas other carriers paid in the range of 60 to 65%. On cross-examination again she had to concede that NJM routinely paid more for code 15101 than other commercial carriers. In her rebuttal testimony, Ms. Gonzalez had to admit that she could not identify the amounts applied to specific patients from the settlement from Blue Cross/Blue Shield. In her rebuttal, she had to admit that NJM paid a least 2.2% more of the charged amount in comparison to other commercial carriers. She also had to admit that in some cases the NJM UCR was greater than the UCR used by the Burn Surgeons. In conclusion her testimony was that NJM paid 73.6% of the charged amount for the services rendered to the injured worker in this case. This percentage is clearly in line with payments made by other commercial carriers and well above payment from government programs.

I find that her change on the Lynch, Reyes and Tresch charts to conform to what she thought was NJM UCR was inappropriate. I find that this change was arbitrary. I find that her failure to

independently verify her changes makes her calculations unreliable. She had no independent basis to make the change. She changed merely to conform.

I further find that her charts were not reliable because they did not include multiple procedure reductions. Her charts showed a payment request of 100% regardless of whether there was a co-surgeon, whether there was a multiple procedure reduction or a modifier attached. In weighing the testimony of Ms. Gonzalez and Ms. Emmons, I find that the testimony of Ms. Emmons was far more accurate and reliable than the testimony offered by Ms. Gonzalez. Ms. Gonzalez had no training in the coding field other than on-the-job experience and an introductory course when she began her employment. I find that she had numerous errors in the compilation of her charts. She could not identify the work done by each surgeon on the operative procedures for G.T.. She could not explain the application of the settlement monies from Blue Cross/Blue Shield to the bills that she testified to on direct. I find that her explanation for changing the NJM UCR simply to conform to what she thought was an error demonstrates her lack of understanding of the regular updating of the Ingenix system. She had no independent verification, and that lack did not concern her. I find that the errors that she described in the NJM charts were minor. I was troubled by her calculations and the preparation of her charts. I find that her percentages and ratios were not reliable because of errors in the entry of the initial data. I find that the EOBs for other carriers, relied on by Ms. Gonzalez, did not support the arguments of the Burn Surgeons for payment for co-surgery. Specifically, the EOB for patient H.V., marked as R -35 in evidence appears to have been changed to buttress the Burns Surgeons' argument. It was submitted as proof that the EOB showed services only for

surgery. However, the documentation sent to NJM did not show that the EOB included additional inpatient services. R-42, an unexpurgated document shows the additional services, which in turn corresponds with the payment made. I was not satisfied with the explanation given by Ms. Gonzalez for the discrepancy in the discovery sent to NJM and the proofs submitted in court.

Ms. Gonzalez had to admit NJM regularly paid more for services rendered by the Burn Surgeon then other commercial carriers, Medicare, Medicaid and Medicaid HMO. She conceded that other carriers refused to pay for co-surgeons for these codes. Respondent's counsel, Ms. DeBellis demolished Ms. Gonzalez' credibility on cross examination.

I considered the testimony of Claudette Mansour. Ms. Mansour is the practice manager for the Burn Surgeons of St. Barnabas. I find that her testimony was not credible. Although she is a member of the American Burn Association and she has served on various committees, she herself is not a certified coder. I find that the manner in which the Burn Surgeons of St. Barnabas determined the current year's fee and how they determine an increase is determined to be totally arbitrary and without regard to any outside reference or control such as the American Burn Association or a consumer index. I find that Ms. Mansour does not have sufficient knowledge to testify as to the use of modifiers or the calculation of usual, customary and reasonable. I find that she does not have the expertise necessary to determine whether or not a modifier should or should not be used. She was unaware of CMS requirements concerning documentation. She was unaware of CMS's role in establishing percentages

assigned to modifiers. She could not provide any substantive argument for charging more for the work done by the Burn Surgeons of St. Barnabas then what would be routinely paid for these procedures.

I had the benefit of the testimony of Ms. Carol Emmons and Ms. Kim Zieglar, witnesses from NJM. I was impressed by their knowledge and the professional quality of their testimony. Certainly, Ms. Emmons had better credentials than the witnesses provided by the petitioner. I find that she had a full understanding of the billing procedures necessary for processing of surgical bills. I find that NJM uses reliable materials respected in the field for the basis of their payment plan. I find that NJM has adopted policies that insure fairness and reasonableness in payment. I find that the process by which NJM processes surgical bills is appropriate. From presentation to payment, NJM has a standard policy in place. NJM has adopted CMS and AMA guidelines. NJM pays according to the data provided by Ingenix, which both parties have stipulated represents the UCR fee for each of the surgical CPT codes. Ms. Emmons did phenomenal work in preparing her charts. I find that her work was precise and accurate. There were only a few minor errors in the more than eleven thousand data entries in the charts which she prepared for testimony. She testified in detail about the source of the data used in her calculations and the formulas that she used. I reviewed her calculations and I concur with her arithmetic. I find that Ms. Emmons confidently explained the actual payment procedures for each of the five surgeries performed on G.T. She explained that although the bill process system rejected the initial bill for services from the Burn Surgeons for G.T. nevertheless after manual review NJM elected to pay at 125%of the UCR for the treatment. This was an internal decision

by NJM predicated on a prior payment for a different worker. I find there was no legal obligation to make the higher payment. The petitioner cannot expect to receive payment at this rate in the future for codes 15000, 15001, 15100 and 15101.

In regard to Ms. Zieglar, I also find that she too was a very reliable witness. I find her testimony to have been competent and expert. She testified in regard to the resource base relative value scale (RBRVS), accepted and adopted by CMS/Medicare and Medicaid services. I find that the reliance that NJM places on this scale as accepted and adopted by CMS to be well placed. Ms. Zieglar was well versed in the implementation of the data from Ingenix in the system used by NJM. She testified about the data and constant updates done.

In considering the testimony of the petitioner's expert, I find that Ms. Modell did not have a level of expertise necessary to assist the petitioner in its case. Although Ms. Modell had some experience in coding, she does not have significant expertise with coding. Her present employer reviews hospital billing with a view towards obtaining more money for the hospital and also obtaining a percentage of increase for her firm. I do accept her testimony however that it is important that medical providers document the treatment rendered and use the appropriate codes and modifiers. I find that Ms. Modell had no basis for determining that it was appropriate for the Burn Surgeons to bill as co-surgeons on these cases. I find that Ms. Modell had no basis for her statement that the Burn Surgeons saved any additional time or expense by the manner in which they did the surgeries. She has had no training to qualify her to give an opinion in this regard. In her testimony, she admitted that she was not really familiar

with the American Burn Association or their Primers. She had to concede that NJM did in fact have payment policies in place and she did have to admit on cross-examination that based on CMS and AMA rules that the codes in this particular case were not eligible for co-surgeon billing. She also had to acknowledge that Dr. Spitz's recitation of the CMS requirements for documentation was correct. She also had to admit that the Burn Surgeons did not prepare the appropriate documentation to support their claim for billing. All in all, I find that her testimony was more helpful to the respondent than to the petitioner. At the end of cross, Ms. Modell had to concede that the Burn Surgeons did not meet the definition or the reporting standards for co-surgery. I cannot accept her assertion that each doctor should receive 87% of UCR for their work as co-surgeon as I find that there was absolutely no basis for this claim. She could not cite any standards to support this position. I further find that her testimony in regard to Ms. Gonzalez' work especially in preparing the attachment C to her report does not withstand scrutiny. She did not independently verify any of the information provided by Ms. Gonzalez. Therefore, she could not testify accurately when the errors made by Ms. Gonzalez in this chart were revealed.

I find that the testimony of Dr. Spitz was far more persuasive and credible. I find that Dr. Spitz has significant experience in the coding field. I find that as a doctor practicing internal medicine that he routinely and regularly uses coding to carry out his own billing. I find that he recognized the need for co-surgeons to be accurate in their reporting and billing and in conformance with the definition of co-surgeons as expressed in the AMA, ABA and CMS guidelines. I find that Dr. Spitz has adequate training and experience to serve as an expert. I find that he had a breadth

of knowledge concerning the development of CPT codes and the development of the resource based relative value scale. Dr. Spitz made it quite clear that in order to qualify as co-surgeons each surgeon must work as a primary surgeon doing distinct parts of a procedure. Each surgeon has a responsibility to report their distinct operative work and each surgeon should report their work using modifier 62.

I am satisfied that Dr. Spitz was well versed in the American Burn Association standards as expressed in the Primers. I note that he did review the Primers available for 2004/2005/2006. I find those Primers to be authoritative in the field. Dr. Spitz testified that the ABA Primers indicate that Medicare allows a total of 125% of the allowable fee for a surgery that permits co-surgeons. Payment is then divided between the two surgeons. This means that each surgeon is paid 62.5% of the allowable amount.

I accept the testimony of respondent's various witnesses concerning the development of the RBRVS scale. I find that the code assigned to a particular procedure by the AMA fairly reimburses the provider. Serious consideration has been given in the development of these codes to the expertise necessary in completing the work. I find that the Burn Surgeons argument that additional monies should be paid because of the difficulty, the severe illness of the patient, and the expertise required to be misplaced. All of these considerations were taken in when the codes were prepared. The argument that greater reimbursement should be made because of the skill of the doctor or the complexity of the case is inappropriate. Clearly, the respondent has demonstrated that a physician using this code whether he be a burn surgeon or an orthopedist has the right to the same reimbursement at the same rates based on all

considerations including geographic location. I reject the Burn Surgeons argument that their cases involve the more seriously ill patient. I find that these codes take into consideration the extent of amount of work that sometimes must done on burn patient. The original code makes an allowance for the initial work thereafter add-on codes are permitted to allow for reimbursement. I find that the seriousness of the case was contemplated when the codes were designed. To make it absolutely clear, this case is not an example of an insurance company substituting its judgment for the judgment of a doctor. The decisions establishing the codes and the modifiers and values attached thereto were made by doctors who thoroughly understood the skills necessary to carry out the procedure. I find that NJM correctly valued the codes used in the 12/27/04 and 1/10/05 surgeries. The petitioner was incorrect in their calculation of total RVUs as clearly shown by their own expert. Ms. Modell used data from 2008 in her original calculation; when she reviewed data from 2004 and 2005 it was obvious that code 15100 had a higher total RVU than code 15120 and that accordingly it was correctly ranked as a primary procedure. The argument offered by petitioner that NJM should have used a facility RBRVS makes no sense as this would have reduced the payment allowance to the petitioner. By choosing to use a non-facility RBRVS NJM pays a portion of the physician's overhead, something not included in a facility RBRVS.

I accept the testimony of Ms. Emmons, Ms. Zieglar and Dr. Spitz when they testified to the need for documentation. I find that the practice by the Burns surgeons of allowing clerks in the billing office to assign modifiers to be in contradiction with accepted practices set forth by the AMA and the ABA. Billing clerks should not determine which codes or modifiers should be added to

the HCFA; this is the job for the physician. It is evident through review of Ms. Gonzalez' testimony that the only instructions given to the billing clerks for the Burns Surgeons in regard to co-surgery was if there were two surgeons in the operating theater it was automatically assumed to be co-surgery and modifier 62 should be attached.

I find that the petitioner, the Burn Surgeons at St. Barnabas has not proved by a preponderance of the evidence before me an entitlement of additional fees from NJM. I find that NJM has made payment to the Burn Surgeons at St. Barnabas at a rate higher than the appropriate payment. NJM paid at 125% of UCR for codes not eligible for payment at this rate. It was in the discretion of NJM to pay the greater amount. There was no obligation on their part to offer increased payment. I find that NJM payments were usual, reasonable and customary. I find that NJM paid the charges of the Burn Surgeons in a manner similar to other payments that were made by other commercial carriers. The petitioner did not prove that other carriers paid for co-surgeries on codes other than 15120 and 15121. I find this to be usual and customary. I find that on average NJM payments met or exceeded other commercial carriers and when considering payments from Medicare/Medicaid /Medicaid HMO greatly exceeded their usual payment. I find this to be reasonable.

Although there is a schedule in place in New Jersey for the PIP law, there is no such schedule available in workers' compensation. As I stated at the outset, this court must defer to the statutory requirement of usual, customary and reasonable. In reviewing the evidence in this case I accept the findings prepared by Ms. Emmons. I find as follows: 1. NJM paid the petitioners, the Burn Surgeons of St. Barnabas, 73.5% of the billed amounts for the codes in

question. 2. Petitioners were paid 60.7% of their charges by all carriers excluding Medicaid/Medicaid HMO and NJM. 3. When excluding Medicaid/Medicaid HMO, NJM paid 17.2% more than other carriers. 4. If Medicaid/Medicaid HMO is included in the reimbursement petitioner has received then NJM's reimbursement rate is 55% more than all the other carriers. I have reviewed the calculations and the formulas used by Ms. Emmons. I find that her work was careful and precise. I reviewed the EOBs on which she based her data, and I find that she correctly transposed the data to her charts. I find that the corrections she made concerned only minor issues. I accept her testimony that NJM paid more than 17.2% then other commercial carriers and that when payment from social programs, Medicare and Medicaid were included that NJM paid 55% more than other payers. The total amount billed to NJM by the Burn Surgeons was $388,251.00; the total payment from NJM to Burn Surgeons was $280,319.60. This represents a ratio of 72.2% which in light of other payments made for similar codes appears to be usual, customary and reasonable.

I find that it is appropriate to recognize the standards set for the American Medical Association and the various subspecialty groups in their definition of the codes and the modifiers that the medical professions use to bill for their services. I find that it is also appropriate to accept the guidelines set forth by the Centers for Medicare and Medicaid services (CMS). I find that the use of CMS guidelines is customary among all payers. I find that the use of the resource base relative value scale (RBRVS) is fair and reasonable. The scale takes into consideration the physician's work, the related practice expenses and the cost of malpractice insurance. This scale can be reduced to a calculation of value. Comparisons can be made and the guidelines

can be applied. I find that the Burn Surgeons inappropriately billed for co-surgery. I find that the Burn Surgeons failed to document each surgery. I find that it was inappropriate for each surgeon to bill for the total amount of excision and grafting done during these surgeries. I find that NJM did not have to compensate the Burn Surgeons at St. Barnabas if the codes were eligible for co-surgery. I find that NJM did elect to do this even though its internal system rejected the bill. I find that it is inappropriate to expect a carrier to pay more than the billed fee regardless of the fee schedule amount.

I find that in considering usual customary and reasonable that it is appropriate to use paid fees as appropriate as opposed to billed fees for services rendered. I find that in determining the usual customary and reasonable allowance it is appropriate to look at all payments made to the medical providers rather those exclusively made by commercial carriers. I find that contractual carriers or government programs should be considered in determining what is customarily accepted by the provider. It is only by reviewing every payment that a determination can be made as to what an acceptable payment is. The instant case is somewhat unusual because it deals with burn surgery. In New Jersey there are very few practitioners. There are none in northern New Jersey to compare with. The fact is, however, that the Burn Surgeons do accept all manners of insurance coverage including self-pay, government programs, contractual payers and commercial carriers. It is possible then to compare what the petitioner deems acceptable from other payers.

I find that there is no justification for claim that the Burn Surgeons are entitled to further payment or that NJM did not meet UCR.

I find that the respondent NJM has proven with clear and convincing evidence that NJM has paid UCR for all services rendered by the Burn Surgeons to the injured worker, G. T..

I find that after reviewing all of the data the only fair and just determination is that NJM has proven that its payments met or exceeded payments for similar codes and modifiers by other payers. As the petitioner has failed to prove its case, I dismiss the claim petition with prejudice. I assess a stenographic fee of $3600.00 against the Petitioner. The Respondent is directed to prepare an Order of Dismissal.

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Virginia M. Dietrich
Administrative Supervisory Judge of Compensation