New Jersey Academy of Otolaryngology-Head & Neck Surgery
New Jersey Academy of Facial Plastic Surgeons

December 2012

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2013 Annual Meeting

April 10, 2013

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From the Statehouse Advocacy and Management Group

REVISED PIP FEE SCHEDULE ADOPTED
The NJ Department of Banking & Insurance has adopted amendments to its Personal Injury Protection (PIP) rule. The new rule caps reimbursement for hundreds of medical procedures. In the final adoption, the only new change was the addition of six codes to the fee schedules that had inadvertently been included in the 117 codes for spinal and neurosurgical procedures.. Retained was the provision that certain spinal procedures will no longer be reimbursed under PIP if performed in an ambulatory surgery center. To see the full rule adoption, visit: http://www.state.nj.us/dobi/pipinfo/aicrapg.htm

NON- PARTICIPATING DOCTORS MUST ENROLL WITH MEDICAID
The Centers for Medicare & Medicaid Services has announced that all physicians who are not

Medicaid participants must enroll as "non-billing" providers if they order for or refer Medicaid patients. This new provision has been included in an effort to update Medicaid protocol as part of the Affordable Care Act and will better allow for participating providers to be paid. As of January 1, 2013, any Medicaid claim submitted by an enrolled Medicaid provider containing the NPI number of an unenrolled medical professional will be denied. In order for payment to be processed. All physicians must be enrolled with CMS as either "billing" or "non-billing."

For those who register as "non-billing," the name of the physician/practice will not be listed in any public Medicaid provider directories. Only enrolled Medicaid providers will be able to access information on "non-billing" providers through a secured website. Please visit the following site for the enrollment application for "non-billing" physicians: http://www.njmmis.com/downloadDocuments/FD-20B.pdf

LAW SUSPENDS LICENSE FOR DUMPING MEDICAL WASTE

The Governor has signed into law a measure that suspends the license of any health care professional, medical waste facility, generator or transporter found in violation of New Jersey's medical waste anti-dumping laws. This law was created in response to illegally dumped medical waste that washed ashore in 2008 and forced many South Jersey beaches to close temporarily. During that period, over 200 syringes and other medical waste were found on Avalon, Berkeley, Ocean City, Sea Isle City, Brigantine and Upper Township beaches. Under the new law, the offender's licenses will be suspended for three years, after which time they will be allowed to apply for reinstatement. If the offender is licensed in a state other than New Jersey, the state Office of the Attorney General will contact the appropriate sister agency to ensure that the offender faces the appropriate penalties. All offenders will be placed on a newly created "Illegal Medical Waste Disposal License and Registration Revocation List" and remain on the list until reinstated.

NJ HEALTH EXCHANGE: UPDATE

The federal government has extended the deadline for states to submit outlines for establishing a state run Health Exchange. If the state does not submit an outline by December 14, the federal government will create and run the Exchange on behalf of the state. While New Jersey accepted $8 million in federal grants to establish the Exchange, it has not yet confirmed its outline. Both the Senate and the Assembly have sent the "New Jersey Health Benefit Exchange Act" to the Governor's desk. The Governor vetoed this bill, in large part because he claims his administration's questions to Health Secretary Kathleen Sibelius have gone unanswered. It is unclear whether New Jersey will go ahead with the Medicaid expansion, which is not mandated per the Supreme Court ruling. (see below for more on Medicaid expansion)

The Exchange is due to begin open enrollment in October 2013. The individual mandate, which requires all Americans to have health insurance or face a penalty, will then begin in January 2014.

MEDICAID EXPANSION UNDER CHRISTIE

Based on the Supreme Court decision in the summer of 2012, the Affordable Care Act (ACA) was deemed legal, with the exception of the Medicaid expansion mandate. Based on the ruling, states can choose whether to participate in the Medicaid expansion. Governor Christie has expressed skepticism about expanding the program, stating direct concerns for the state budget.

An expansion of Medicaid would attempt to include adults without children who are over 26 percent of the federal poverty level, or who earn more than $2,900 per year, as these individuals are not currently covered in New Jersey. The expansion coverage will only apply to new Medicaid enrollees. According to the Rutgers Center on State Health Policy, the expansion of Medicaid would provide health coverage to 234,000 new residents.

The federal government will cover 100 percent of the cost of expanding eligibility for these 234,000 New Jerseyans from 2014 to 2016. After the initial two years, the state will be required to gradually contribute up to ten percent, with the federal government contributing up to 90 percent of the cost. The Governor is concerned with the overall effects of the 10 percent contribution on the state budget.

Even if the Governor decides to expand Medicaid coverage, there is a possibility that patients will have difficulty finding doctors who are willing to accept the program's low reimbursement rate. Under the ACA, Medicaid reimbursement rates will become equal to Medicare rates, which many hope will entice doctors to take Medicaid patients. After the initial two years, Medicaid rates will no longer match that of Medicare. It is important to note that under the fiscal cliff, Medicare reimbursement rates will be cut by 27 percent, thus lowering the bar for the two year Medicaid reimbursement match.

Legal Report **Kern Augustine Conroy & Schoppmann, PC**

Revised PIP Medical Fee Schedule Adopted: After months of proposals, comments and re-proposals and further comments, the NJ Department of Banking & Insurance (DOBI), on November 15, 2012, adopted amendments to its Personal Injury Protection (PIP) rule, to be effective 60 (sixty) days thereafter. The initial proposal of PIP rule amendments came in August 2011. Because of the large volume of comments to that proposal, in February 2012 DOBI issued a Notice of Proposed Substantial Changes, with a new round of comments. The November 5th adoption made only a minor change from the amendments and new rules announced in the February 2012 Notice. It added six codes to the fee schedules that had inadvertently been included in the 117 codes for spinal and neurosurgical procedures that were removed in the last proposal.

The final adoption includes a Physicians' and ASC Fee Schedule and a separate Hospital Outpatient Surgical Facility (HOSF) fee schedule, with higher rates for facilities where hospital out-patients are treated. DOBI based the higher HOSF rates on the Medicare fee schedule assigning higher practice costs to procedures performed in hospital non-emergency outpatient facilities than performed in ASCs. The proposed rules had also provided a mechanism for setting fees for procedures not previously on the PIP fee schedule, with reference to the FAIR Health (www.fairhealthus.org) database. The NJ Society of Plastic Surgeons had previously challenged DOBI's assertion that 85% of the codes have values above the 75th percentile of the FAIR Health schedule, as belied by an

examination of the low fees paid for plastic surgery codes. DOBI did not revise those fees, although DOBI's actual calculations based on the FAIR Health database remain under challenge.

Many procedures will not be payable under PIP at all if performed in an ASC, including over 100 codes for "low frequency, high-cost procedures"performed by neurosurgeons and spine surgeons.DOBI based the total exclusion of some procedures from the ASC fee schedule on the determination by CMS that the risk of performing those procedures in an ASC is "unacceptably high," while approving them for HOSFs at a much higher rate. DOBI had previously commented that removing these procedures from the ASC fee schedule is based on patient safety, not patient choice or the cost of the procedure and that doing so does not usurp a physician's medical decision-making, stating: "[O]n the contrary, since many physicians have a financial interest in ASCs, the decision about where to perform the procedure may be influenced by financial factors."
Among the revised and new provisions (beginning with the August 2011 proposal and now part of the final adoption):

- "Ambulatory surgical case" is defined as a procedure that is not minor surgery as defined in Medical Board regulations.
- Deletion of the proposed definition "outpatient surgical facility"which had been defined to mean an ASC, a doctor's office where ambulatory surgical cases are performed or a facility where non-emergency hospital outpatients are treated. (DOBI commentary: "The definition of ASC already included a physician-owned single operating room in an office setting that is certified by Medicare. DOBI believes those are the only types of doctors' offices that can receive facility fees.")
- Specific language for determination of UCR and treatment of codes that have changed after the fee schedule's adoption.
- Specific links to manuals and other sources for determination of codes and documentation.
- Provisions regarding bundling and fragmented billing, including specification that moderate (conscious) sedation (CPT codes 99143 through 99145) performed by the physician who also furnishes the medical or surgical service cannot be reimbursed separately for the procedures listed in Appendix G of the CPT manual.
- Codes that do not have an amount in the ASC facility fee column are not reimbursable if performed in an ASC.
- Specification of what services are covered by the ASC facility fee.
- The multiple procedure reduction formula is set forth.
- Changes to the internal appeals process, the dispute resolution process, and the assignment of benefits provision which now permits an insurer to require that a provider accept the policy's duty to cooperate if assigned by the insured.
- Workers Compensation Managed Care Organization networks will not be included under the PIP fee schedule, pending further study by DOBI.

Physicians should carefully review all changes made from first proposal to final adoption. The document reflecting these changes, as well as the full adopted rule and fee schedules, can be accessed athttp://www.state.nj.us/dobi/pipinfo/aicrapg.htm. An application to stay the regulations before they become effective in January was denied by DOBI on November 23rd and is pending judicial review. The DOBI Commissioner's Order A12-114 denying the stay is available at the above link.

NJHA Petitions SBME to Allow Corporate Employment of Physicians:
The NJ Hospital Association (NJHA) has petitioned the NJ State Board of Medical Examiners

(Board) to revise its current regulations regarding employment of physicians by a corporation. The NJHA asserts that a corporation should be permitted to employ a physician if: (i) the corporation is a wholly controlled subsidiary of a licensed hospital and is monitored by that hospital through quality assessment and performance improvement programs, the structure of which is available to the Board, upon request; (ii) the corporation does not exercise control over its employee physicians' independent medical judgments; and (iii) part of the corporate governance structure is a committee comprised solely of licensed physicians tasked with making all corporate decisions involving the exercise of independent medical judgment. Under the proposed changes, physicians would also be permitted to have input into the governance of the corporation with regard to matters that are not purely clinical. The NJHA believes such changes are necessary for hospitals and physicians to form collaborations-such as Accountable Care Organizations--envisioned by Federal and State law, and that this exception to New Jersey's prohibition on the corporate practice of medicine would protect physician autonomy in such entities.

Appeals Court Rules on Physician's Duty to Report Child Abuse: The NJ Superior Court, Appellate Division, has provided a new interpretation of the statutory duty to report child abuse, which should result in increased reporting. The opinion is mandatory reading for all pediatric, family, and emergency room physicians, but understanding just how to meet the less than bright line standard may be difficult. The lawsuit alleged that the emergency room physician had committed medical malpractice by, among other things, failing to comply with the New Jersey statute requiring any person having reasonable cause to believe that a child has been subjected to child abuse to report the same immediately to the Division of Child Protection & Permanency (previously DYFS). In this case, although the physician conducted extensive tests when the 2-year old presented vomiting and unsteady, with a 0.035 percent blood alcohol level, he apparently did not inquire fully before concluding that the child's condition resulted from ingesting cologne from a container later brought to the ER by the child's father, and deciding to not report the incident for further investigation. In the coming months, the child was the victim of numerous incidents of child abuse and was removed from the father's home and later adopted. The Appellate panel reversed the lower court's dismissal of the adoptive parent's suit, finding that, under the statute, a physician has "reasonable cause to believe" that there has been abuse if a "probable inference" from the medical and factual information available to the physician is that the child's condition is the result of child abuse, including "reckless" or "grossly or wantonly negligent" conduct or inaction by a parent or caregiver. The Court said that the inference need not be the "most probable," but must be more than speculation or suspicion. The Court held that a reasonable jury could find that a probable inference from the information available to the physician at the time was that the child's condition resulted from reckless or grossly or wantonly negligent parental conduct or inaction and that the physician breached the standard of care by failing to report. Although the physician in this case ultimately could be exonerated, the new standard requires immediate attention by those who treat minors. The decision, L.A. v DYFS, is available at www.drlaw.com
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For more information on any of the above items, contact Kern Augustine at 1-800-445-0954.