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CLOSING THE DOOR ON UCR IN CASES INVOLVING AMBULATORY SURGERY CENTERS (ASCS): THE APPELLATE DIVISION BRINGS AN END TO AN ERA OF PIP ARBITRATIONS AND LITIGATION

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The ongoing question of whether or not an ambulatory surgery center (ASC) can be paid for services not listed on the fee schedule has recently been answered with an emphatic **"NO"** by New Jersey's Appellate Division. On January 29, 2019, the Appellate Division's decision in New Jersey Manufacturers Insurance Company v. Specialty Surgical Center of North Brunswick a/s/o Claire Fiore, and Surgicare Surgical Associates of Fair Lawn a/s/o Martino Chizzoniti (A-0319-17T1 & A0388-17T1) was approved for publication – putting an end to a hotly disputed issue among PIP practitioners.

For years, Forthright arbitrators (known as DRPs) have been fairly split on this issue. Some DRPs have been consistent in denying reimbursement to ASCs unless the ASC fee schedule includes a specified amount for the codes billed. Other DRPs have entertained arguments to allow ASCs in such circumstances to have their bill either (1) cross-walked to a similar service listed on the Hospital Outpatient Surgical Facility (HOSF) Fees; or (2) paid pursuant to UCR if Medicare allows reimbursement for such codes. Inevitably, this resulted in a substantial number of arbitrations involving ASC billing. In turn, this led the Department of Banking and Insurance (DOBI) to revise its published response to an FAQ to address this issue head-on. Superior Court judges were also split on how to resolve these disputes. As a result, both sides racked up quite a few wins by way of Orders to Show Cause. Again, this only led to more arbitrations and litigation since both sides now had judicial (albeit, unpublished) opinions to support their arguments. This issue finally came to a head recently when two NJM cases involving two different ASCs were heard together before the same Appellate Division panel of judges. Notably, the Insurance Council of New Jersey (ICNJ) and the Property Casualty Insurers Association of America (PCIAA) also participated in both cases amicus curiae. NJM, ICNJ & PCIAA are hereinafter referred to as "Respondents" for brevity.

The Facts:

Although both cases involved different ASCs who billed NJM on different claims, the Appellate Division heard these together since they involved a dispute over the same surgical code – CPT 63030. This code is not listed on the ASC fee schedule, but does appear on the HOSF with a reimbursement rate of $13,940.72 for the North Region.

In the Fiore case, the insured underwent a lumbar discectomy at Specialty Surgical Center of North Brunswick (Specialty Surgical) who billed $32,500 for CPT 63030. In the Chizzoniti case, the insured underwent lumbar decompression surgery at Surgicare Surgical Associates of Fair Lawn (Surgicare) who billed $49,000 for CPT 63030. Coincidentally, both procedures were performed at Specialty Surgical and Surgicare in November of 2015. NJM denied payment to both ASCs who then proceeded to file demands for arbitration with Forthright pursuant to N.J.A.C. 11:3-5.1(a).

The underlying DRPs and appellate DRP panels found against NJM's position in both cases and awarded payments to be made to the ASCs.

NJM then sought to vacate the awards pursuant to N.J.S.A. 2:A:23A-13 of the Alternative Procedure for Dispute Resolution Act (APDRA), arguing a mistake of law had been committed below. The trial judge vacated both awards and found that the ASCs were prohibited from receiving reimbursement of any kind in connection with ASC fees for CPT 63030.

Specialty Surgical and Surgicare appealed.

The Jurisdictional Issue:

The APDRA provides a party seeking to vacate, modify or correct an award the ability to bring a "summary action" in the Superior Court. That trial court level of review is intended by the enabling statute to provide the final level of appellate review. Looking to Mt. Hope Development Associate v. Mt. Hope Waterpower Project, 154 N.J. 141, 152 (1998), the Appellate Division recognized there were "'rare circumstances'…where public policy would require appellate court review."

Citing Kimba Med. Supply v. Allstate Ins. Co., 431 N.J. Super. 463 (App. Div. 2013), the Appellate Division found that public policy supports review of the trial court's decisions in these cases since continued conflicting interpretations of the fee schedule would likely lead to more litigation – contrary to the Legislature's intent behind AICRA. Specifically, the court here invoked the public policy exception because:

> "the issue before us: 1) had only been addressed in unpublished cases; 2) involved matters that 'should not be guessed at by the participants from case to case,' including '[t]he repeat players in the PIP system – claimants, insurers, DRPs, lawyers, and trial judges-' who could all 'benefit from definitive precedential guidance'; and 3) involved a matter of statutory interpretation."

Recognizing that both DRPs and Superior Court judges have been inconsistent in interpreting the applicable PIP regulations, with no published cases addressing this issue, the Appellate Division exercised their authority under the APDRA to review these cases. The Appellate Division also recognized that failing to act without guiding precedent would lead to more litigation, with associated costs and delays.

Parenthetically, the jurisdictional question was not challenged by any of the parties at oral argument. The consensus was that the PIP community needed clarity on this question.

The ASCs' Arguments:

The ASCs presented three arguments to the Appellate Division: (1) that ASC billing was consistent with the intent of AICRA in that it tended to be lower than the rates payable to hospitals for the same treatment; (2) that DOBI incorporated Medicare's payment guidelines "wholesale" into our PIP Regulations; and (3) that our PIP Regulations permit non-payable codes to be cross-walked to similar services listed on the HOSF fee schedule, or in the absence of any such similar services, UCR.

On the first argument, the ASCs suggested to the court that their billing comported with AICRA since they were a lower-cost alternative to having the same procedures performed in a hospital outpatient setting. However, upon questioning from the Appellate Panel, counsel for the ASCs reluctantly admitted that their client's billed rates for CPT 63030 were higher than the allowable HOSF rates. The ASCs then suggested that payment at the HOSF rates would be fair to all parties involved.

The ASC's second argument was that DOBI adopted Medicare "wholesale" when it implemented the current fee schedule. They cited N.J.A.C. 11:3-29.4(g) and argued that DOBI intended for the ASC fee schedule to be interpreted in accordance with the Medicare Claims Processing Manual. In the case of CPT 63030, they argued that although DOBI declined to include that code on the ASC fee schedule, Medicare updated its guidelines to permit reimbursement of that code when performed in an ASC. Therefore, the code should now be paid by PIP carriers.

This argument naturally flowed into the ASC's third argument—that the payable amount should be consistent with either the HOSF rates for the same codes, or in the alternative, UCR.

Respondents' Arguments:

In opposing the ASC's first argument, Respondents pointed out that the Claimants' billed rates exceeded the HOSF by a substantial amount, thereby belying the ASCs' contention that their billing comported with AICRA.

On the ASCs' second argument regarding Medicare, Respondents guided the Appellate panel to consider the plain meaning of N.J.A.C. 11:3-29.4(g) which starts out with the words:

> "**Except as specifically stated to the contrary in this subchapter**, the fee schedules shall be interpreted in accordance with the following, incorporated herein by reference, as amended and supplemented: the relevant chapters of the Medicare Claims Processing Manual, updated periodically by CMS, that were in effect at the time the service was provided."

(Emphasis added). Respondents then pointed to the language in N.J.A.C. 11:3-29.5(a) as DOBI's "statement to the contrary" where it says:

> **"ASC facility fees are listed in Appendix, Exhibit 1, by CPT code. Codes that do not have an amount in the ASC facility fee column are not reimbursable if performed in an ASC."**

Respondents further argued that N.J.A.C.11:3-29.4(e)(3) expressly prohibits consideration of a "similar services" analysis to determine payable amounts for ASC codes not listed on the fee schedule. That section plainly states:

> "3. Codes in Appendix, Exhibit 1 that do not have an amount in the ASC facility fee column are not reimbursable if performed in an ASC and are not subject to the provision in (e) above concerning services not set forth in or covered by the fee schedules."

Lastly, Respondents argued that DOBI's clear intent on this issue was crystalized in its original and revised answers to FAQ #6 which dealt with this precise question. The original version of DOBI's response to FAQ #6 read as follows:

> N.J.A.C. 11:3-29.5(a) states that services for which there is no fee in the ASC facility fee column of Appendix, Exhibit 1 are not

reimbursable if performed in an ASC. Stated another way, the only facility fees for services that are reimbursable if performed in an ASC are those CPT and HCPCS codes that have facility fees listed in the ASC facility fee column of Appendix, Exhibit 1. HOWEVER, the Department inadvertently omitted the "N1" payment indicator from a number of services in Appendix, Exhibit 1 that are performed in ASCs. These "N1" payment indicators are found in CMS' Addendum AA – Final ASC Covered Surgical Procedures for CY 2011 (MS Excel); PDF version.

The "N1" payment indicator means that the service can be performed in an ASC but a facility fee is not separately reimbursable because the service is included in another procedure. The list of codes for which the "N1" payment indicator should have been included in Appendix, Exhibit1 can be found here (MS Excel) (or PDF version).

Respondents highlighted the fact that after DOBI learned that some ASCs were seeking payment for non-listed codes via a Medicare theory (and succeeding in doing so at arbitration), DOBI revised its response to FAQ #6 to remove any doubt about their position on this issue. DOBI updated its response to FAQ #6 to read:

> N.J.A.C. 11:3-29.5(a) and 29.4(e)3 state that when there is no fee in the ASC facility fee column of Appendix, Exhibit 1 for a service, the facility fee for that service is not reimbursable if performed in an ASC. Stated another way, the only facility fees that are reimbursable for services performed in an ASC are those CPT and HCPCS codes that have facility fees listed in the ASC Facility Fee Column of Appendix, Exhibit 1. The fact that, subsequent to the promulgation of the fee schedule rule, CMS may have authorized additional procedures to be performed in an ASC does not permit an ASC to be reimbursed for those services unless there is an amount listed in the ASC Fee Column on Appendix, Exhibit 1 for the corresponding CPT code. However, certain codes that do not have fees in the ASC facility fee column have "N1" in the payment indicator column. The "N1" payment indicator means that the service can be performed in an ASC but a facility fee is not separately reimbursable because the service is included in another procedure. N.J.A.C. 11:3-29.5(a) and 29.4(e)3 apply only to facility fees and do not apply to physician services.

In sum, Respondents argued that the court should defer to DOBI's own guidance as to the interpretation of its own PIP regulations.

The Appellate Division's Decision:

In reaching its decision, the court acknowledged the long history of legal challenges posed against DOBI's regulation of ASC reimbursement in PIP cases. They noted that the current fee schedule provides reimbursement to doctors but not ASCs for CPT 63030. The Appellate Division concluded that ASCs should not receive reimbursement for 63030 since no reimbursement was listed on the ASC columns of the fee schedule. They interpreted this omission as a clear indication of DOBI's intent not to reimburse providers for this (and any other) non-listed procedures. The court found that Medicare's decision to add CPT codes to their fee schedule does not result in the automatic amendment of our PIP fee schedule. Rather, they concluded that DOBI, not Medicare, amends the PIP fee schedule.

Impact on PIP:

This decision signals the end of UCR disputes with ASCs for non-listed codes. Carriers now have the comfort of knowing their payment decisions in this regard should be upheld if challenged. Carriers no longer need to use a "similar service" analysis to cross-walk ASC codes. This case provides a bright-line rule which should be easy to implement going forward.

Only ten days after its published decision was released in these cases, the Appellate Division issued an unpublished decision on a companion case which was argued on December 11, 2018 along with the Specialty Surgical and Surgicare Surgical cases. This third case involved an ASC who billed CPT 62290 which is listed on the ASC fee schedule with no payment amount. In Endo Surgical Center a/s/o Bernadette Harper v. NJM Insurance Group (A-1934-17T3), the Appellate Division reversed a trial court's decision to award reimbursement for CPT 62290. In the underlying case, the trial court found that CPT 62290 was payable since Medicare added this code to its ASC fee schedule. On appeal, NJM argued that CPT 62290 is listed on Medicare's ASC fee schedule with an 'N1' modifier, meaning the code is for a packaged procedure which is not separately reimbursable. Although normally billed with other procedures and considered as included in other charges, CPT 62290 was the only code billed by the ASC in this case. Consistent with its arguments in the Specialty Surgical and Surgicare Surgical cases, NJM argued that DOBI's regulations and FAQ responses provide clear guidance that this code is not payable in PIP since it is listed on the PIP fee schedule with no payable amount. Citing the Specialty Surgical and Surgicare Surgical cases, the Appellate Division rejected the argument that the PIP fee schedule is amended when Medicare permits reimbursement to an ASC for a specific CPT code.

For medical providers, these decisions will likely cause such surgical treatment to occur in hospitals rather than in ASCs, which may still lead to UCR disputes for codes which are not listed on the HOSF fee schedule. However, the industry may cheer the fact that they have a definitive statement of where they stand against ASC UCR billing.

For DRPs and judges, this decision provides a much-needed interpretation of how to consistently determine ASC disputes involving non-listed CPT codes as well as CPT codes with no reimbursement amount listed on the ASC fee schedule. This likely will result in fewer Forthright arbitrations, Forthright appeals and Orders to Show Cause by either side seeking to overturn errant awards and decisions.

Relevance to BI practitioners?

For those BI attorneys asking why they've read this far into a PIP article, you may find some professional utility from this case. If facing a BI case with boardable medical bills which include ASC bills with CPT codes that are not payable pursuant to the PIP fee schedule, consider whether this case might support a pre-trial motion to limit that exposure.