

CHAPTER 3
AUTOMOBILE INSURANCE

Authority

N.J.S.A. 17:1-8.1 and 17:1-15e.

Source and Effective Date

R.2006 d.243, effective June 7, 2006.
See: 37 N.J.R. 4162(a), 38 N.J.R. 2828(c).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 3, Automobile Insurance, expires on December 4, 2013. See: 45 N.J.R. 1886(a).

Chapter Historical Note

Chapter 3, New Jersey Automobile Insurance Plan, was adopted as R.1972 d.20, effective January 31, 1972. See: 3 N.J.R. 223(d), 4 N.J.R. 49(d).

Subchapter 7, Automobile Reparation Reform Act, was adopted as R.1972 d.244, effective December 4, 1972. See: 4 N.J.R. 270(a), 5 N.J.R. 13(c).

Subchapter 10, Auto Physical Damage Claims, was adopted as R.1976 d.46 and R.1976 d.47, effective May 1, 1976. See: 8 N.J.R. 38(b), 8 N.J.R. 136(b).

Pursuant to Executive Order No. 66(1978), Subchapter 8, Nonrenewal of Automobile Insurance Policies, was readopted as R.1983 d.190, effective June 6, 1983. See: 15 N.J.R. 231(a), 15 N.J.R. 927(a).

Subchapter 12, Automobile Rate Filers: Flattening of Premium Taxes and Assessments Made for the Unsatisfied Claim and Judgment Fund, was adopted as R.1983 d.424, effective October 3, 1983. See: 15 N.J.R. 1170(a), 15 N.J.R. 1666(a).

Subchapter 13, Automobile Rate Filers: Deductibles for Private Passenger Automobile Collision and Comprehensive Coverage, was adopted as R.1983 d.467, effective October 17, 1983. See: 15 N.J.R. 1342(a), 15 N.J.R. 1769(b).

Pursuant to Executive Order No. 66(1978), Subchapter 6, Insurance Identification Card, was readopted as R.1983 d.648, effective December 29, 1983. See: 15 N.J.R. 1919(a), 16 N.J.R. 145(c).

Public Notice: Automobile Insurance Written Notice/Buyer's Guide Coverage Selection Form. See: 16 N.J.R. 254(d).

Subchapter 15, Standards for Written Notice: Buyer's Guide and Coverage Selection Form, was adopted as R.1984 d.114, effective April 2, 1984. See: 15 N.J.R. 2142(a), 16 N.J.R. 733(a).

Subchapter 14, Personal Injury Protection Options, was adopted as R.1984 d.116, effective April 2, 1984. See: 15 N.J.R. 2139(a), 16 N.J.R. 730(b).

The Executive Order No. 66(1978) expiration date of Subchapter 7, Automobile Reparation Reform Act, was extended by gubernatorial directive from August 17, 1984 to November 15, 1984, and was further extended by gubernatorial directive from November 15, 1984 to February 13, 1985. See: 17 N.J.R. 43(a).

Pursuant to Executive Order No. 66(1978), Subchapter 7, Automobile Reparation Reform Act, was readopted as R.1985 d., effective February 13, 1985. See: 17 N.J.R. 43(a), 17 N.J.R. 707(b).

Subchapter 17, Rating Organizations, was adopted as R.1985 d.609, effective October 6, 1985. See: 16 N.J.R. 2936(a), 17 N.J.R. 2905(a).

Pursuant to Executive Order No. 66(1978), Chapter 3, Automobile Insurance, was readopted as R.1985 d.654, effective January 6, 1986, operative May 6, 1986. See: 16 N.J.R. 3286(a), 17 N.J.R. 89(b).

Subchapter 20, Reporting Financial Disclosure and Excess Profit Reports, was adopted as R.1986 d.111, effective April 7, 1986. See: 17 N.J.R. 2597(a), 18 N.J.R. 692(a).

Subchapter 17, Rating Organizations, was repealed and Subchapter 17, Rating Organizations, was adopted as new rules by R.1986 d.419, effective October 6, 1986. See: 18 N.J.R. 1171(b), 18 N.J.R. 2045(a).

Subchapter 22, Coverage Option Survey: Personal Injury Protection and Tort Threshold Options, was adopted as R.1986 d.463, effective November 17, 1986. See: 18 N.J.R. 1344(b), 18 N.J.R. 2329(a).

Subchapter 23, Dangerous Drivers or Drivers with Excessive Claims, was adopted as R.1987 d.527, effective December 21, 1987. See: 19 N.J.R. 1880(a), 19 N.J.R. 2403(b).

Public Notice: Rescission of Circular Letter #75. See: 19 N.J.R. 570(e).

Subchapter 26, Accident Claims, Subchapter 27, Unsatisfied Claim and Judgment Fund Board, and Subchapter 28, Unsatisfied Claim and Judgment Fund's Reimbursement of Excess Medical Expense Benefits Paid by Insurers, were adopted as R.1989 d.268, effective May 15, 1989. See: 21 N.J.R. 688(a), 21 N.J.R. 1363(a).

Subchapter 20, Reporting Financial Disclosure and Excess Profit Reports, was repealed and Subchapter 20, Reporting Financial Disclosure and Excess Profit Reports, was adopted as new rules by R.1989 d.277, effective May 15, 1989. See: 21 N.J.R. 667(b), 21 N.J.R. 1335(a), 21 N.J.R. 1517(b).

Subchapter 24, Policy Constants, and Subchapter 25, Residual Market Equalization Charges (RMECs), were adopted as R.1989 d.278, effective May 15, 1989. See: 20 N.J.R. 3104(a), 21 N.J.R. 1358(b).

Subchapter 20A, Standard Limiting Effect of Negative Excess Investment Income in the Computation of Excess Profits, was adopted as R.1989 d.306, effective June 5, 1989. See: 21 N.J.R. 842(a), 21 N.J.R. 1517(c).

Subchapter 17, Rating Organizations, was repealed by R.1989 d.328, effective June 19, 1989. See: 21 N.J.R. 973(a), 21 N.J.R. 1708(a).

Subchapter 30, Motor Vehicle Self-Insurance, was adopted as R.1989 d.584, effective November 20, 1989. See: 21 N.J.R. 2876(a), 21 N.J.R. 3666(b).

Subchapter 31, Examination of the Financial Experience of Private Passenger Automobile Insurers, was adopted as R.1990 d.108, effective February 5, 1990. See: 21 N.J.R. 3726(a), 22 N.J.R. 425(a).

Subchapter 18, Private Passenger Automobile Insurance: Rate Filing Review Procedures, was adopted as R.1990 d.109, effective February 5, 1990. See: 21 N.J.R. 3422(b), 22 N.J.R. 421(a).

Subchapter 16, Rate Filing Requirements: Voluntary Market Private Passenger Automobile Insurance, was adopted as R.1990 d.116, effective February 5, 1990. See: 21 N.J.R. 2182(a), 22 N.J.R. 399(a).

Subchapter 1, Provisions and Operations, was repealed and Subchapter 1, Commercial Automobile Insurance Plan, was adopted as new rules by R.1990 d.118, effective February 5, 1990. See: 21 N.J.R. 3613(a), 22 N.J.R. 392(b).

Subchapter 16A, Flex Rate Percentage Calculations for Private Passenger Automobile Insurance, was adopted as R.1990 d.161, effective March 19, 1990. See: 21 N.J.R. 3719(a), 22 N.J.R. 963(a).

Subchapter 34, Eligible Persons Qualifications and Automobile Insurance Eligibility Points Schedule, was adopted as emergency new rules by R.1990 d.620, effective November 26, 1990, operative April 1, 1991, to expire January 25, 1991. See: 22 N.J.R. 3847(a). The provisions of R.1990 d.620 were readopted as R.1991 d.93, effective

January 25, 1991, operative April 1, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3847(a), 23 N.J.R. 572(a)

Subchapter 36, Automobile Physical Damage Insurance Inspection Procedures, was adopted as emergency new rules by R.1990 d.622, effective November 26, 1990, operative March 1, 1991, to expire January 25, 1991. See: 22 N.J.R. 3861(a). The provisions of R.1990 d.622 were readopted as R.1991 d.95, effective January 25, 1991, operative October 1, 1992, with changes effective February 19, 1991. See: 22 N.J.R. 3861(a), 23 N.J.R. 579(a), 23 N.J.R. 1132(c).

Subchapter 38, Towing and Storage Fee Schedule, was adopted as emergency new rules by R.1990 d.623, effective November 26, 1990, operative January 1, 1991, to expire January 25, 1991. See: 22 N.J.R. 3874(a). The provisions of R.1990 d.623 were readopted as R.1991 d.97, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3874(a), 23 N.J.R. 592(a).

Subchapter 29, Medical Fee Schedules: Automobile Insurance Personal Injury Protection Coverage, was adopted as emergency new rules by R.1990 d.624, effective November 26, 1990, operative January 1, 1991, to expire January 25, 1991. See: 22 N.J.R. 3809(a). The provisions of R.1990 d.624 were readopted as R.1991 d.96, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3809(a), 23 N.J.R. 536(a).

Subchapter 37, Order of Benefit Determination Between Automobile Personal Injury Protection and Health Insurance, was adopted as emergency new rules by R.1990 d.625, effective November 26, 1990, to expire January 25, 1991. See: 22 N.J.R. 3777(a). The provisions of R.1990 d.625 were readopted as R.1991 d.90, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3777(a), 23 N.J.R. 597(a).

Subchapter 35, Private Passenger Automobile Insurance Underwriting Rules, was adopted as emergency new rules by R.1990 d.627, effective November 26, 1990, to expire January 25, 1991. See: 22 N.J.R. 3856(a). The provisions of R.1990 d.627 were readopted as R.1991 d.94, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3856(a), 23 N.J.R. 577(a).

Subchapter 19, Standard/Non-Standard Rating Plans, was adopted as emergency new rules by R.1990 d.628, effective November 26, 1990, to expire January 25, 1991. See: 22 N.J.R. 3804(a). The provisions of R.1990 d.628 were readopted as R.1991 d.92, effective January 25, 1991, with changes effective February 19, 1991. See: 22 N.J.R. 3804(a), 23 N.J.R. 532(a).

Pursuant to Executive Order No. 66(1978), Chapter 3, Automobile Insurance, was readopted as R.1991 d.45, effective January 4, 1991, and Subchapters 2 through 5, concerning the Automobile Insurance Plan (AIP), were repealed by R.1991 d.45, effective February 4, 1991. See: 22 N.J.R. 1678(a), 23 N.J.R. 306(b).

Subchapter 24, Policy Constants, was repealed by R.1991 d.216, effective April 15, 1991. See: 22 N.J.R. 3441(a), 23 N.J.R. 1132(a).

Subchapter 25, Residual Market Equalization Charges (RMECs), was repealed by R.1991 d.217, effective April 15, 1991. See: 22 N.J.R. 3442(a), 23 N.J.R. 1132(b).

Subchapter 39, Reductions in Premium Charges for Private Passenger Automobiles Equipped with Anti-Theft, Vehicle Recovery and Safety Features, was adopted as R.1991 d.363, effective July 15, 1991, operative September 1, 1991. See: 23 N.J.R. 384(a), 23 N.J.R. 2144(a).

Subchapter 33, Appeals from Denial of Automobile Insurance, was adopted as R.1992 d.192, effective April 30, 1992. See: 24 N.J.R. 546(a), 24 N.J.R. 1510(a).

Subchapter 40, Insurers Required to Provide Automobile Insurance Coverage to Eligible Persons, was adopted as R.1992 d.207, effective May 4, 1992. See: 23 N.J.R. 3736(a), 24 N.J.R. 336(a), 24 N.J.R. 1796(b).

Subchapter 2, New Jersey Personal Automobile Insurance Plan, was adopted as new rules by R.1992 d.370, effective September 21, 1992. See: 24 N.J.R. 331(a), 24 N.J.R. 3400(a).

Subchapter 3, Limited Assignment Distribution Servicing Carriers, was adopted as new rules by R.1992 d.371, effective September 21, 1992. See: 24 N.J.R. 519(a), 24 N.J.R. 3414(a).

Subchapter 42, Producer Assignment Program, was adopted as emergency new rules by R.1992 d.381, effective September 4, 1992, to expire November 3, 1992. See: 24 N.J.R. 3421(a). The provisions of R.1992 d.381 were readopted as R.1992 d.482, effective November 2, 1992, with changes effective December 7, 1992. See: 24 N.J.R. 3421(a), 24 N.J.R. 4397(a).

Subchapter 44, Special Rules for Effecting Coverage for Private Passenger Automobile Insurance, was adopted as emergency new rules by R.1993 d.135, effective March 1, 1993, operative March 8, 1993, to expire April 30, 1993. See: 25 N.J.R. 1290(a). The provisions of R.1993 d.135 were readopted as R.1993 d.238, effective April 30, 1993. See: 25 N.J.R. 1290(a), 25 N.J.R. 2479(a).

Subchapter 2B, Market Transition Facility of New Jersey Suspension of Claims, was adopted as emergency new rules by R.1994 d.164, effective March 1, 1994, to expire April 30, 1994. See: 26 N.J.R. 1393(a). The provisions of R.1994 d.164 were readopted as R.1994 d.261, effective April 29, 1994. See: 26 N.J.R. 1393(a), 26 N.J.R. 2288(a).

Subchapter 32, Certification of Compliance: Mandatory Liability Coverages, was adopted as R.1994 d.477, effective September 19, 1994. See: 26 N.J.R. 1939(a), 26 N.J.R. 3866(a).

Subchapter 31, Examination of the Financial Experience of Private Passenger Automobile Insurers, was repealed by R.1995 d.171, effective March 20, 1995. See: 27 N.J.R. 41(a), 27 N.J.R. 1190(b).

Subchapter 45, Insurers Required to Provide Survey Information, was adopted as R.1995 d.235, effective May 1, 1995. See: 27 N.J.R. 289(a), 27 N.J.R. 1803(a).

Pursuant to Executive Order No. 66(1978), Chapter 3, Automobile Insurance, was readopted as R.1996 d.58, effective January 4, 1996, and Subchapter 2A, New Jersey Automobile Full Insurance Underwriting Association Claims Payment Deferral, Subchapter 3, Limited Assignment Distribution Servicing Carriers, and Subchapter 23, Dangerous Drivers or Drivers with Excessive Claims, were repealed by R.1996 d.58, effective February 5, 1996. See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

Subchapter 20A, Standard Limited Effect of Negative Excess Investment Income in the Computation of Excess Profits, was repealed by R.1996 d.312, effective July 15, 1996. See: 28 N.J.R. 1616(a), 28 N.J.R. 3627(b).

Subchapter 25, Private Passenger Automobile Insurance: Notification by Treating Health Care Providers, was adopted as new rules by R.1997 d.14, effective January 6, 1997. See: 28 N.J.R. 3876(a), 29 N.J.R. 132(a).

Subchapter 24, Defensive Driving Rate Reductions, was adopted as new rules by R.1997 d.522, effective December 15, 1997. See: 28 N.J.R. 4854(a), 29 N.J.R. 5305(a).

Subchapter 28A, Unsatisfied Claim and Judgment Fund Assessments, was adopted as R.1997 d.535, effective December 15, 1997. See: 29 N.J.R. 4246(a), 29 N.J.R. 5309(a).

Subchapter 19A, Tier Rating Plans and Underwriting Rules, was adopted as R.1998 d.129, effective March 2, 1998. See: 29 N.J.R. 5253(a), 30 N.J.R. 839(a).

Subchapter 46, Automobile Insurance Urban Enterprise Zone Program, was adopted as R.1998 d.290, effective June 1, 1998. See: 30 N.J.R. 773(a), 30 N.J.R. 2010(a).

Subchapter 3, Basic Automobile Insurance Policy, was adopted as new rules by R.1998 d.592, effective December 21, 1998, operative March 22, 1999. See: 30 N.J.R. 3209(a), 30 N.J.R. 4398(a).

Subchapter 5, Personal Injury Protection Dispute Resolution, was adopted as new rules by R.1998 d.593, effective December 21, 1998. See: 30 N.J.R. 3359(a), 30 N.J.R. 4437(a).

Subchapter 4, Personal Injury Protection Benefits; Medical Protocols; Diagnostic Tests, was adopted as new rules by R.1998 d.597, effective December 21, 1998, operative March 22, 1999. See: 30 N.J.R. 3211(a), 30 N.J.R. 3748(a), 30 N.J.R. 4401(a).

Subchapter 38, Towing and Storage Fee Schedule, was repealed by R.1999 d.1, effective January 4, 1999. See: 30 N.J.R. 2813(a), 31 N.J.R. 54(c).

Pursuant to Executive Order No. 66(1978), Chapter 3, Automobile Insurance, was readopted as R.2001 d.44, effective January 4, 2001, and Subchapter 2B, Market Transition Facility of New Jersey Payment Prioritization and Claims Payment Deferral, Subchapter 16A, Flex Rate Percentage Calculations for Private Passenger Automobile Insurance, Subchapter 19, Standard/Nonstandard Rating Plans, and Subchapter 42, Producer Assignment Program, were repealed by R.2001 d.44, effective January 4, 2001. See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

Subchapter 17, Rate Intervenor Rules, was adopted as new rules by R.2001 d.270, effective August 6, 2001. See: 33 N.J.R. 1305(a), 33 N.J.R. 2694(a).

Subchapter 16B, Rate Process For Limited Rate Changes; Calculations for Private Passenger Automobile Insurance Rate Changes, was adopted as new rules, by R.2001 d.481, effective December 17, 2001. See: 33 N.J.R. 2574(a), 33 N.J.R. 4371(a).

Subchapter 3A, Reporting Requirements and Filing Deadlines, was adopted as new rules, by R.2003 d.95, effective March 3, 2003. See: 34 N.J.R. 3470(a), 35 N.J.R. 1289(a).

Subchapter 2A, Special Automobile Insurance Policy, was adopted as new rules, by R.2003 d.497, effective December 15, 2003. See: 35 N.J.R. 3519(b), 35 N.J.R. 5599(a).

Subchapter 47, Insurance Scenarios, was adopted as new rules, by R.2004 d.118, effective March 15, 2004. See: 35 N.J.R. 4434(a), 36 N.J.R. 1587(a).

Subchapter 35A, Private Passenger Automobile Insurance—Use of Alternate Underwriting Rules, was adopted as new rules, by R.2004 d.165, effective April 19, 2004. See: 35 N.J.R. 4429(a), 36 N.J.R. 1929(a).

Subchapter 16A, Private Passenger Automobile Insurance Territorial Rating Plans, was adopted as new rules, by R.2005 d.126, effective April 18, 2005. See: 36 N.J.R. 3979(a), 37 N.J.R. 1197(a).

Chapter 3, Automobile Insurance, was readopted by R.2006 d.243, effective June 7, 2006. See: Source and Effective Date. See, also, section annotations.

Subchapter 12, Automated Rate Filers: Flattening of Premium Taxes and Assessments Made for Unsatisfied Claim and Judgment Fund, was renamed Automobile Rate Filers: Flattening of Premium Taxes, by R.2006 d.243, effective July 3, 2006. See: 37 N.J.R. 4162(a), 38 N.J.R. 2828(c).

Subchapter 17, Rate Intervenor Rules, was repealed by R.2006 d.243, effective July 3, 2006 (operative July 16, 2006). See: 37 N.J.R. 4162(a), 38 N.J.R. 2828(c).

Subchapter 8, Renewal and Nonrenewal of Automobile Insurance Policies, was renamed Acceptance, Renewal, Nonrenewal and Cancellation of Automobile Insurance Policies; Subchapter 19A, Tier Rating Plans and Underwriting Rules, was renamed Tier Rating Plans and Tier Placement Criteria; and Subchapter 35, Private Passenger Automobile Insurance Underwriting Rules, Subchapter 35A, Private Passenger Automobile Insurance—Use of Alternate Underwriting Rules, Subchapter 40, Insurers Required to Provide Automobile Insurance Coverage to Eligible Persons, Subchapter 44, Special Rules for Effecting Coverage for Private Passenger Automobile Insurance and Subchapter 47, Insurance Scenarios, were repealed by R.2008 d.380, effective December 15, 2008 (operative January 1, 2009). See: 40 N.J.R. 3572(a), 40 N.J.R. 6970(b).

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 3, Automobile Insurance, was scheduled to expire on June 7, 2013. See: 43 N.J.R. 1203(a).

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**SUBCHAPTER 1. COMMERCIAL AUTOMOBILE
INSURANCE PLAN**

11:3-1.1 Purpose and scope

(a) The purpose of this subchapter is to establish a plan pursuant to N.J.S.A. 17:29D-1:

1. To provide the coverages described herein, subject to the conditions stated, for motor vehicles other than those vehicles subject to the New Jersey Personal Automobile Insurance Plan;

2. To provide for the apportionment of insurance coverage for qualified applicants who are in good faith entitled to but are unable to procure the same, through the voluntary market; and

3. To establish a procedure for the sharing of premiums, losses, and expenses among all insurers who are participants in New Jersey as defined within this subchapter for all risks qualified for coverage under the provisions of this subchapter.

Amended by R.1996 d.58, effective February 5, 1996.

See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

Amended by R.1996 d.502, effective October 21, 1996.

See: 27 N.J.R. 4489(a), 28 N.J.R. 4586(a).

Amended by R.2003 d.415, effective October 20, 2003.

See: 35 N.J.R. 2391(a), 35 N.J.R. 4900(a).

In (a), inserted "other" preceding "private passenger vehicle" in 1, substituted "qualified" for "eligible" preceding "applicants" in 2 and substituted "qualified" for "eligible" preceding "for coverage" in 3.

Amended by R.2008 d.380, effective December 15, 2008 (operative January 1, 2009).

See: 40 N.J.R. 3572(a), 40 N.J.R. 6970(b).

In (a)1, deleted "and any other private passenger vehicle that is owned by or driven by a person who meets the definition of an eligible person pursuant to N.J.S.A. 17:33B-13 and N.J.A.C. 11:3-34" from the end.

11:3-1.2 Definitions

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

"Actively writing" means an insurer writing commercial automobile liability or physical damage insurance in this State in the voluntary or involuntary market. This includes new business and/or renewals.

"CAIP" or "Plan" means the Commercial Automobile Insurance Plan pursuant to this subchapter.

"CAIP manager" means the entity employed by the Governing Committee to manage and conduct the administrative affairs of the CAIP on a daily basis.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"Emergency type vehicle" means any land vehicle, used to respond to distress calls, fires, or rescue, propelled by other than muscular power and not run upon rails or tracks. This term includes, but is not limited to, fire trucks, rescue trucks, police cars and ambulances.

"Gross participation" means a participant's Voluntary All Other Automobile Direct Written Premiums derived from information contained in the annual statement times a fraction, the numerator of which is the sum of the plan's total written premiums for that year and the Statewide total Voluntary All

Other Automobile Direct Written Premiums which are eligible for depopulation credit for that policy year, and the denominator of which is the Statewide total Voluntary All Other Automobile Net Direct Written Premiums of all participants for that second prior year.

"Light truck" means a vehicle with a gross vehicle weight (G.V.W.) of 10,000 pounds or less.

"Motor vehicle" means any land vehicle propelled otherwise than by muscular power including trailers and semi-trailers, except such vehicles that run only upon rails or tracks.

"Net participation" means a participant's gross participation for that policy year less its business eligible for depopulation credit for that policy year.

"Net participation percentage" means a participant's net participation for that policy year in proportion to the comparable Statewide total net participation for all participants.

"Operating headquarters" means the chief place of business where the principal officers generally transact business, and the place to which reports are made and from which orders emanate. It is the location where the executive offices are, corporate decisions are made and corporate functions are performed.

"Participant" means an insurer licensed and authorized to write motor vehicle liability or physical damage insurance and specifically includes any insurer who writes all other automobile liability and all other automobile physical damage insurance.

"Personal injury protection" means those benefits as set forth at N.J.S.A. 39:6A-4.

"Policy year" means the exposure and premiums for all policies written during a calendar year and all losses attributable to policies written during the same calendar year.

"Private passenger automobile" means a vehicle that meets the definition in N.J.S.A. 39:6A-2a, that is not eligible for coverage through any voluntary or residual market mechanism created by statute, and is owned by an individual or husband and wife; or owned jointly by two or more relatives other than husband and wife; or owned jointly by two or more resident individuals; or owned by a corporation, partnership or unincorporated association, governmental agency, or registered to a professional designation (that is, T/A, PA or P.C.) where such automobiles are furnished to individuals and are not used for business purposes.

for approval with the Department their rates, rules and policy forms for a basic automobile insurance policy to be issued in accordance with N.J.S.A. 39:6A-3.1 and this subchapter.

(b) An insurer shall make available the basic policy at either a single tier rate or at multiple tier rates, consistent with its tier rating system filed and approved pursuant to N.J.A.C. 11:3-19A. If more than one basic policy rate is offered, each shall be identified as part of a standard, non-standard or preferred tier.

(c) If a named insured has elected basic automobile insurance coverage and other immediate family members or resident relatives of the named insured have higher policy limits under a standard policy, the provisions of N.J.S.A. 39:6A-4.2 shall apply and the named insured shall only be entitled to the coverages provided under his or her basic policy.

(d) Basic policies shall provide the tort option provided under N.J.S.A. 39:6A-8a.

(e) Initial rates by coverage for basic policies filed in accordance with this subchapter shall demonstrate consistency with the rates in the insurer's standard policy, adjusted for reduced coverage limits.

(f) Insurers shall file for approval an initial basic policy rating system by January 20, 1999.

(g) An insurer may write basic policies through a basic policy servicing carrier.

Amended by R.2007 d.151, effective May 7, 2007.
See: 38 N.J.R. 2376(a), 39 N.J.R. 1731(a).
Added (g).

11:3-3.4 Coverages; mandatory and optional

(a) The following coverages shall be included in all basic policies:

1. Personal injury protection medical expense benefits coverage in an amount not to exceed \$15,000 per person, per accident; except that all medically necessary treatment of permanent or significant brain injury, spinal cord injury or disfigurement or medically necessary treatment of other permanent or significant injuries rendered at a trauma center or acute care hospital immediately following the accident and until the patient is stable, no longer requiring critical care and can be safely discharged or transferred to another facility in the judgment of the attending physician shall be covered in an amount not to exceed \$250,000, including the \$15,000 above. The medical expense benefits provided herein shall be in accordance with N.J.A.C. 11:3-4; and

2. Liability insurance coverage insuring against loss resulting from liability imposed by law for property damage sustained by any person arising out of the ownership, maintenance, operation or use of an automobile in an amount or

limit of \$5,000, exclusive of interest and costs, for damage to property in any one accident.

(b) Insurers shall also make available in the basic policy, at the option of the insured, liability insurance coverage for bodily injury or death in an amount or limit of \$10,000, exclusive of interest and costs, on account of the injury or death of one or more persons in any one accident.

(c) Insurers may make available with the basic policy, at the option of the insured, comprehensive and collision coverage with deductibles filed and approved pursuant to N.J.A.C. 11:3-13.

(d) Basic policies shall not contain any other coverages, options, limits or deductibles other than those which are set forth in (a) through (c) above. Increased policy limits, the health insurance primary option for automobile medical expense coverage and uninsured/under-insured motorist coverages shall not be provided in basic policies.

11:3-3.5 Election of basic automobile insurance policy coverage and reporting

No insurer shall issue a basic automobile insurance policy unless the named insured has signed a written document entitled "basic automobile insurance policy coverage selection form" set forth in N.J.A.C. 11:3-15.7.

Amended by R.2003 d.95, effective March 3, 2003.
See: 34 N.J.R. 3470(a), 35 N.J.R. 1289(a).

In (b), deleted "as of December 31" following "exposures", deleted ", and filed no later than the next occurring February 15" following "Commissioner" and added a N.J.A.C. reference.

Amended by R.2006 d.243, effective July 3, 2006.
See: 37 N.J.R. 4162(a), 38 N.J.R. 2828(c).

Deleted designation (a) and deleted (b).

11:3-3.6 Filing requirements

(a) Insurers initially filing basic policy rating systems shall include the following:

1. A complete set of policy forms and endorsements that provide the mandatory and optional coverages as set forth in this subchapter;
2. Rates and rules as necessary;
3. An actuarial memorandum that supports the rate differentials from the insurer's standard policy rates;
4. The declaration page;
5. The rating information form; and
6. The personal lines filing forms as set forth in N.J.A.C. 11:3-16.3(f) and (g).

(b) Subsequent amendments to the rating systems shall be filed pursuant to N.J.A.C. 11:3-16 and other applicable statutes and rules.

SUBCHAPTER 3A. REPORTING REQUIREMENTS
AND FILING DEADLINES

11:3-3A.1 Purpose and scope

(a) This subchapter consolidates reporting obligations from various rules into one subchapter to result in one efficient, time-saving procedure.

(b) This subchapter applies to all insurers that write private passenger automobile insurance in this State as defined in N.J.A.C. 11:3-3A.2.

11:3-3A.2 Definitions

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

“Insurer” means any person authorized to write automobile insurance in New Jersey, including any residual market mechanism, and includes all affiliated companies with a group.

“Private passenger automobile” means a vehicle that meets the definition of “automobile” set forth at N.J.S.A. 39:6A-2.

11:3-3A.3 Report requirements

(a) All private passenger automobile insurers are required to file the following reports on a semi-annual basis, reflecting data from the last 12 months, and showing the residual market separately from the voluntary data, for the evaluation dates of December 31 and June 30 of each year:

1. The Consolidated Report;
2. The Limits of Liability Report;
3. The Coverage Option Survey—Personal Injury Protection (“PIP”) Deductibles, Threshold Options; and
4. PIP Medical Expense Limits Report.

(b) The Consolidated Report shall include the following reports: In Force Exposures; Primary Classification; and Basic versus Standard Exposures.

1. The Consolidated Report shall be filed in accordance with the template found at <http://www.state.nj.us/dobi>. The Consolidated Report forms shall be filed for the following four subheadings:

- i. Voluntary Standard Policy In-Force Exposure and Written Premiums;
- ii. Voluntary Basic Policy In-Force Exposures and Written Premiums;
- iii. Voluntary Special Automobile Insurance Plan In-Force Exposures and Written Premiums;
- iv. PAIP Standard Policy In-Force Exposures and Written Premiums; and

v. PAIP Basic Policy In-Force Exposures and Written Premium.

2. The Consolidated Report shall:

- i. Include the total number of exposures for each report itemized by classification and territory;
- ii. Include in-force exposure and written premium for each of 12 classifications (three for SAIP) based on age, gender and use; and
- iii. Not be modified in any way.

(c) The Limits of Liability Report shall be provided on seven separate spreadsheets and shall be filed in accordance with the template found at <http://www.state.nj.us/dobi> which itemizes limits of liability by territory for the following subheadings:

1. Standard policy no threshold—bodily injury split limits of liability;
2. Standard policy verbal threshold—bodily injury split limits of liability;
3. Standard policy verbal threshold—property damage split limits of liability;
4. Standard policy no threshold—property damage split limits of liability;
5. Standard policy verbal threshold—combined single limit;
6. Standard policy no threshold—combined single limit; and
7. Basic policy—liability limits.

(d) The Coverage Option Survey—PIP Deductibles, Threshold Options Report shall be filed in accordance with the template found at <http://www.state.nj.us/dobi>, and shall:

1. Be filed for both standard policies and basic policies;
2. Reflect the total number of automobiles with inforce coverage; and
3. Indicate the named driver exclusion, medical expense only, personal injury protection deductible, health primary or automobile primary and lawsuit threshold or no threshold options selected with respect to each automobile by territory and total.

(e) The PIP Medical Expense Limits Report shall be filed in accordance with the template found at <http://www.state.nj.us/dobi>, listing the total number of standard and basic combined in-force exposures for the six standard medical expense limits (\$15,000; \$50,000; \$75,000; \$150,000; \$250,000; and excess of \$250,000) and total by territory.

(f) Reports with an evaluation date of December 31 shall be due by January 31.

(g) Reports with an evaluation date of June 30 shall be due by July 31.

(h) Reports shall be submitted using the Excel templates, available on the Department's website at <http://www.state.nj.us/dobi> on one of the following media:

1. E-mail (preferred media);
2. CD-ROM; or
3. Floppy Diskette.

(i) The Excel templates shall not be modified by the user in any way.

(j) Reports shall be submitted to:

New Jersey Department of Banking and Insurance
Office of Property and Casualty
PO Box 325
Trenton, NJ 08625-0325
E-mail: reports@dobi.state.nj.us

Amended by R.2006 d.243, effective July 3, 2006.
See: 37 N.J.R. 4162(a), 38 N.J.R. 2828(c).

In (h), substituted "<http://www.state.nj.us/dobi>" for "<http://www.state.nj.us/dobi>".

Amended by R.2008 d.75, effective April 7, 2008.
See: 39 N.J.R. 4538(a), 40 N.J.R. 1875(a).

In the introductory paragraph of (b), deleted "Tier Report;" following "Primary Classification;"; added new (b)1iii; recodified former (b)1iii and (b)1iv as (b)1iv and (b)1v; in (b)2i, deleted ", tier" following "classification"; deleted former (b)2ii; recodified former (b)2iii and (b)2iv as (b)2ii and (b)2iii; in (b)2ii, inserted "(three for SAIP)"; in (b)2iii, deleted "except to include extra tiers within the original spreadsheet for insurers who have additional tiers not listed on the template" following "any way"; and in (i), deleted "except as stated above in (b)2iv above" following "any way".

11:3-3A.4 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties pursuant to N.J.S.A. 17:33-2 and as otherwise authorized by law.

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

11:3-4.1 Scope and purpose

(a) This subchapter implements the provisions of N.J.S.A. 39:6A-3.1, 39:6A-4 and 39:6A-4.3 by identifying the personal injury protection medical expense benefits and emergency personal injury protection coverage for which reimbursement of eligible charges will be made by automobile insurers under basic, standard and special automobile insurance policies and by motor bus insurers under medical expense benefits coverage.

(b) This subchapter applies to all insurers that issue policies of automobile insurance containing PIP coverage, emer-

gency personal injury protection coverage and policies of motor bus insurance containing medical expense benefits coverage.

(c) This subchapter shall apply to those policies that are issued or renewed on or after March 22, 1999.

Amended by R.2004 d.218, effective June 7, 2004 (operative October 27, 2004).

See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a), 36 N.J.R. 4319(a).

In (a), inserted "and emergency personal injury protection coverage" following "medical expense benefits", deleted "and" following "automobile insurers under basic", inserted "and special automobile insurance" preceding "policies and by motor bus insurers"; in (b), inserted "emergency personal injury protection coverage" following "automobile insurance containing PIP coverage".

Case Notes

Statute and the regulations promulgated by the Commissioner represented a complex legislative and regulatory package designed to reform automobile insurance law in New Jersey, and the courts of New Jersey were in the best position to consider the validity of the applicable regulations under state law. *Chiropractic America v. Lavachchia*, 180 F.3d 99 (3rd Cir. N.J. 1999).

Uninsured passenger, not qualified to receive Medicaid, who receives emergency personal injury protection benefits under the driver's special automobile insurance policy is entitled to personal injury protection coverage from the Unsatisfied Claim and Judgment Fund for non-emergency medical treatment. *Sanders v. Langemeier*, 401 N.J. Super. 125, 949 A.2d 295, 2008 N.J. Super. LEXIS 134 (App.Div. 2008).

Associations representing personal injury attorneys and health-care providers for automobile accident victims had standing to challenge approval of automobile policies by the commissioner of Banking and Insurance. *Quality Health Care v. DOBI*, 348 N.J. Super. 272, 791 A.2d 1085.

11:3-4.2 Definitions

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

"Ambulatory surgery facility" or "ambulatory surgical center" (ASC) means:

1. A surgical facility, licensed as an ambulatory surgery facility in New Jersey in accordance with N.J.A.C. 8:43A, in which ambulatory surgical cases are performed and which is separate and apart from any other facility license. (The ambulatory surgery facility may be physically connected to another licensed facility, such as a hospital, but is corporately, financially and administratively distinct, for example, it uses a separate tax-id number); or

2. A physician-owned single operating room in an office setting that is certified by Medicare.

"Basic automobile insurance policy" or "basic policy" means those private passenger automobile insurance policies issued in accordance with N.J.S.A. 39:6A-3.1 and N.J.A.C. 11:3-3.

“Clinically supported” means that a health care provider prior to selecting, performing or ordering the administration of a treatment or diagnostic test has:

1. Personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment or test;
2. Physically examined the patient including making an assessment of any current and/or historical subjective complaints, observations, objective findings, neurologic indications, and physical tests;
3. Considered any and all previously performed tests that relate to the injury and the results and which are relevant to the proposed treatment or test; and
4. Recorded and documented these observations, positive and negative findings and conclusions on the patient’s medical records.

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

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

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

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

“Decision point” means those junctures in the treatment of identified injuries indicated by hexagonal boxes on the Care Paths where a decision must be made about the continuation or choice of further treatment. The determination whether to administer one of the tests listed in N.J.A.C. 11:3-4.5(b) is also a decision point for both identified and all other injuries.

“Decision point review” means the procedures in an insurer’s approved decision point review plan for the insurer to receive notice and respond to requests for proposed treatment or testing at decision points.

“Diagnostic test” means a medical service or procedure utilizing biomechanical, neurological, neurodiagnostic, radiological, vascular or any means, other than bioanalysis, intended to assist in establishing a medical, dental, physical

therapy, chiropractic or psychological diagnosis, for the purpose of recommending or developing a course of treatment for the tested patient to be implemented by the treating practitioner or by the consultant.

“Eligible charge” means the treating health care provider’s usual, customary and reasonable charge or the upper limit of the medical fee schedule as found in N.J.A.C. 11:3-29.6, whichever is lower.

“Emergency care” means all medically necessary treatment of a traumatic injury or a medical condition manifesting itself by acute symptoms of sufficient severity such that absence of immediate attention could reasonably be expected to result in: death; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. Such emergency care shall include all medically necessary care immediately following an automobile accident, including, but not limited to, immediate pre-hospitalization care, transportation to a hospital or trauma center, emergency room care, surgery, critical and acute care. Emergency care extends during the period of initial hospitalization until the patient is discharged from acute care by the attending physician. Emergency care shall be presumed when medical care is initiated at a hospital within 120 hours of the accident.

“Emergency personal injury protection coverage” means the coverage provided by a Special Automobile Insurance Policy pursuant to section 45 of P.L. 2003, c.89.

“Health care provider” or “provider” means those persons licensed or certified to perform health care treatment or services compensable as medical expenses and shall include, but not be limited to:

1. A hospital or health care facility that is maintained by State or any political subdivision;
2. A hospital or health care facility licensed by the Department of Health and Senior Services;
3. Other hospitals or health care facilities designated by the Department of Health and Senior Services to provide health care services, or other facilities, including facilities for radiological and diagnostic testing, free-standing emergency clinics or offices, and private treatment centers;
4. A nonprofit voluntary visiting nurse organization providing health care services other than a hospital;
5. Hospitals or other health care facilities or treatment centers located in other States or nations;
6. Physicians licensed to practice medicine and surgery;
7. Licensed chiropractors;
8. Licensed dentists;
9. Licensed optometrists;
10. Licensed pharmacists;

Amended by R.1993 d.158, effective April 5, 1993.

See: 24 N.J.R. 4486(a), 24 N.J.R. 56(a), 25 N.J.R. 1543(a).

Added "Amount(s) paid to the MTF".

Amended by R.1996 d.58, effective February 5, 1996.

See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

Deleted definition of "Public Advocate".

Amended by R.1998 d.128, effective March 2, 1998.

See: 29 N.J.R. 5240(a), 30 N.J.R. 828(a).

Inserted "Expenses": in "Filer", inserted a reference to rating organizations, and deleted a reference to flex rate filing; deleted "Flex rate" and "Flex rate filing"; and inserted "Loss cost multiplier", "Prior approval filing", "Prospective loss cost", "Rate", "Supplementary rate information", and "Tier" and "tier rating system".

Amended by R.2003 d.173, effective May 5, 2003.

See: 34 N.J.R. 3475(a), 35 N.J.R. 1907(a).

Deleted "AIP", "Amount(s) paid to the MTF", "MTF" and "NJAFIUA"; in "All other coverages", inserted "New Jersey" preceding "page 14".

Amended by R.2003 d.499, effective December 15, 2003.

See: 35 N.J.R. 3084(a), 35 N.J.R. 5604(a).

Rewrote "Expenses" and deleted "UCJF".

Amended by R.2005 d.176, effective June 6, 2005.

See: 36 N.J.R. 5640(a), 37 N.J.R. 2026(a).

Rewrote the section.

Amended by R.2008 d.380, effective December 15, 2008 (operative January 1, 2009).

See: 40 N.J.R. 3572(a), 40 N.J.R. 6970(b).

In definition "Tier" and "tier rating system", substituted "tier placement criteria" for "underwriting rules", and inserted a comma after the N.J.A.C. reference.

11:3-16.3 General requirements and filing format

(a) The data requirements set forth in this subchapter are minimum requirements. The filer may submit any other data it believes to be relevant in justifying proposed rate changes. If the filer has not collected portions of this information in the

past, or has not collected it in a form so as to facilitate reporting, it is not required to compile it retrospectively.

(b) Separate insurance companies that are affiliated by a parent-subsidiary or any group relationship and that choose to submit a single filing for the group shall provide the minimum data requirements set forth in N.J.A.C. 11:3-16.8, 16.9, and 16.10, either:

1. Separately for each company with a different rate level or different acceptance criteria; or

2. Combined for those companies of the group, which use a common rating system, including both base rates and acceptance criteria, or when the difference is based only on expense differences.

(c) All filings shall be submitted to the Department through the use of the NAIC electronic filing system SERFF (System for Electronic Rate and Form Filing).

(d) All filings shall be accompanied by the following certification signed by an officer of the filer: "I _____ certify that the attached filing complies with all statutory and regulatory requirements and that all the information it contains is true and accurate. I further certify that I am authorized to execute this certification on behalf of the filer."

(e) All data shall be reported on a direct basis exclusive of business ceded to reinsurers or reinsurance assumed from other companies.

Emergency Amendment, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).

See: 22 N.J.R. 3790(a).

Provisions added to confirm that rate filings should contain only voluntary market data and not include data from risks that may be insured through the assigned risk plan to be instituted pursuant to section 34 of the Act.

Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.

See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).

Provision of emergency amendment, R.1990 d.621, readopted with changes effective February 19, 1991.

Amended by R.1996 d.58, effective February 5, 1996.

See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

Deleted requirement to send filings to the Public Advocate.

Amended by R.1998 d.128, effective March 2, 1998.

See: 29 N.J.R. 5240(a), 30 N.J.R. 828(a).

In (a), deleted the former fourth and fifth sentences; in (d), changed the mailing address; deleted former (i); recodified former (j) as (i); recodified former (k) as (j), and substituted "prior approval rate or lost cost" for "rate" in the first sentence; and added new (k) and (l).

Amended by R.2001 d.44, effective February 5, 2001.

See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

Amended by R.2002 d.101, effective April 1, 2002.

See: 33 N.J.R. 1875(a), 34 N.J.R. 1431(b).

Rewrote (e).

Amended by R.2003 d.173, effective May 5, 2003.

See: 34 N.J.R. 3475(a), 35 N.J.R. 1907(a).

In (g), added "A total of three copies shall be submitted." at the end of the paragraph.

Amended by R.2003 d.499, effective December 15, 2003.

See: 35 N.J.R. 3084(a), 35 N.J.R. 5604(a).

In (i), deleted reference to the transactions with UCJF.

Amended by R.2005 d.176, effective June 6, 2005.

See: 36 N.J.R. 5640(a), 37 N.J.R. 2026(a).

Rewrote the section.

Amended by R.2007 d.91, effective April 2, 2007.

See: 38 N.J.R. 4976(b), 39 N.J.R. 1313(a).

Rewrote (d).

Amended by R.2008 d.380, effective December 15, 2008 (operative January 1, 2009).

See: 40 N.J.R. 3572(a), 40 N.J.R. 6970(b).

In (b)1 and (b)2, substituted "acceptance criteria" for "underwriting guidelines"; and in (b)2, inserted a comma after "group".

Amended by R.2009 d.190, effective June 15, 2009.

See: 41 N.J.R. 365(a), 41 N.J.R. 2486(a).

Rewrote (c); deleted former (d); and recodified former (e) and (f) as (d) and (e).

11:3-16.4 Insurer informational filings due July 1 of each year

(a) Informational filings shall be made by all insurers transacting private passenger automobile insurance in the voluntary market, including all individual members and subscribers of rating organizations, pursuant to N.J.S.A. 17:29A-36.2b.

(b) The information filing shall consist of the following documents:

1. The insurer's Excess Profits Report for each company filed pursuant to N.J.A.C. 11:3-20. In lieu of providing copies, the filer may submit a certification of an officer that the report has been filed and is incorporated by reference.

2. Such other specific information on a particular subject at a particular time as the Commissioner may require by Order.

Emergency Amendment, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).

See: 22 N.J.R. 3790(a).

Deleted (b)2. through 8.; added new 2.

Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.

See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).

Provision of emergency amendment, R.1990 d.621, readopted with changes effective February 19, 1991.

Amended by R.1995 d.171, effective March 20, 1995.

See: 27 N.J.R. 41(a), 27 N.J.R. 1190(b).

11:3-16.5 (Reserved)

Emergency Amendment, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).

See: 22 N.J.R. 3790(a).

Amended to implement provisions of the Fair Automobile Insurance Reform Act of 1990, P.L. 1990, c.8.

Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.

See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).

Provision of emergency amendment, R.1990 d.621, readopted without change.

Amended by R.1992 d.189, effective April 20, 1992.

See: 23 N.J.R. 3199(a), 24 N.J.R. 1504(a).

Rate calculation to be included in memo.

Amended by R.1995 d.171, effective March 20, 1995.

See: 27 N.J.R. 41(a), 27 N.J.R. 1190(b).

Amended by R.1996 d.58, effective February 5, 1996.

See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

Repealed by R.1998 d.128, effective March 2, 1998.

See: 29 N.J.R. 5240(a), 30 N.J.R. 828(a).

Section was "Insurer flex rate filings".

11:3-16.6 Filings for rates requiring prior approval

(a) Any filer that desires to modify its rates or rating systems in a manner other than that provided by N.J.S.A. 17:29A-46.6 shall provide the following standard information in support of its application:

1. A cover letter notifying the Department of its intention to modify its rating system in a manner that requires prior approval, pursuant to N.J.S.A. 17:29A-14; a statement describing the proposed changes, which shall include the proposed effective date of the change, and the name, telephone number and mailing address of the company officer familiar with the filing, to whom inquiries about the filing may be directed. Filers may choose to eliminate the submission of a cover letter provided that the SERFF Filing's General Information Filing Description Section is fully completed with a clear and precise description of the filing;

2. A checklist that sets forth the information in Exhibit A in the Appendix incorporated herein by reference;

3. Exhibit B in the Appendix incorporated herein by reference;

4. A narrative overview that sets forth the contents of the filing, and explains the reasons and procedures used to derive the rate change requested;

5. Premiums, losses and loss adjustment expenses data, as set forth in N.J.A.C. 11:3-16.8;

6. Expense data, as set forth in N.J.A.C. 11:3-16.9. Rating organizations are exempt from this requirement;

7. Profit and contingency provision, as set forth in N.J.A.C. 11:3-16.10. Rating organizations are exempt from this requirement;

8. Proposed rates or loss costs for each territory and coverage together with their derivation;

9. Calculations showing that the proposed rates are in compliance with N.J.S.A. 17:29A-36; and

10. Data described in N.J.A.C. 11:3-16.8, 16.9 and 16.10 shall be submitted through the use of the NAIC electronic filing system SERFF (System for Electronic Rate and Form Filing). The information shall be provided in a Microsoft Excel 2003 or compatible spreadsheet. All calculated values shall be given as a formula in the spreadsheet.

(b) All rate filers shall submit data in support of their application for approval of their proposed rating system based on their own loss experience to the extent it is credible (N.J.A.C. 11:3-16.8), their own expense and profit provisions (N.J.A.C. 11:3-16.9) except rating organizations, and their own profit and contingency provision (N.J.A.C. 11:3-16.10). If the application is not supported by the required data, filers shall submit other appropriate documentation as necessary in addition to the required data. Those filers who refer, without

deviation, to the loss experience data of a rating organization shall not be required to file their own loss experience data.

(c) Upon approval, insurers shall file manual rating pages on or before the effective date of the rates. In the case of rating organizations, the manual rating page shall reflect the loss cost information.

(d) In those cases where, due to their small size and/or lack of historical experience, filers are unable to completely fulfill all of the data submission requirements set forth in N.J.A.C. 11:3-16.8, 16.9 and 16.10, such filers shall be required to submit as much required information as they are able to supply, and each filing shall be reviewed accordingly.

(e) Filers shall provide any additional rate filing information specifically requested by the Department that may be necessary to constitute a proper rate filing.

Emergency Amendment, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).

See: 22 N.J.R. 3790(a).

Provisions to implement the Fair Automobile Insurance Reform Act of 1990, P.L. 1990, c.8.

Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.

See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).

Provision of emergency amendment, R.1990 d.621, readopted without change.

Amended by R.1996 d.58, effective February 5, 1996.

See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

Amended (a)1 and 5, and added (a)6.

In (a)1 eliminated the exclusion of the policy constant and RMEC from the grand total.

Amended by R.1998 d.128, effective March 2, 1998.

See: 29 N.J.R. 5240(a), 30 N.J.R. 828(a).

In (a), inserted a reference to loss costs in 4, added an exception at the beginning of 5, inserted a reference to loss cost calculations in 6, and changed N.J.A.C. references and deleted a reference to 5.25 inch 360 KB disks in 7; in (b), inserted an exception relating to rating organizations and inserted a reference to loss cost calculations in the first sentence, and added a second sentence; and rewrote (c).

Amended by R.2003 d.173, effective May 5, 2003.

See: 34 N.J.R. 3475(a), 35 N.J.R. 1907(a).

Rewrote the section.

Amended by R.2005 d.176, effective June 6, 2005.

See: 36 N.J.R. 5640(a), 37 N.J.R. 2026(a).

Rewrote the section.

Amended by R.2007 d.91, effective April 2, 2007.

See: 38 N.J.R. 4976(b), 39 N.J.R. 1313(a).

In (a)1, inserted the last sentence.

Amended by R.2009 d.190, effective June 15, 2009.

See: 41 N.J.R. 365(a), 41 N.J.R. 2486(a).

In (a)1, substituted "inquiries" for "inquires" and substituted "SERFF Filing's General Information Filing Description Section" for "Filing Description" of the NAIC Uniform Property and Casualty Transmittal Document referenced in N.J.A.C. 11:3-16.3(d)"; and rewrote (a)10.

11:3-16.7 (Reserved)

Emergency Repeal and New Rule, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).

See: 22 N.J.R. 3790(a).

Formerly entitled Rating Organization Filings; new rule to implement section 69 of the Fair Automobile Insurance Reform Act of 1990, P.L. 1990, c.8.

Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.

See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).

Provision of emergency amendment, R.1990 d.621, readopted with changes effective February 19, 1991.

Amended by R.1995 d.288, effective June 5, 1995.

See: 27 N.J.R. 1356(a), 27 N.J.R. 2232(b).

Rewrote (i), extending its application indefinitely.

Amended by R.1996 d.58, effective February 5, 1996.

See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

In (a)4v substituted "costs" for "cuts", and rewrote (i) to eliminate model year limitation.

Repealed by R.1998 d.128, effective March 2, 1998.

See: 29 N.J.R. 5240(a), 30 N.J.R. 828(a).

Section was "Jointly developed historical data".

11:3-16.8 Premiums, loss costs, loss and loss adjustment expense data

(a) Filers shall provide the following data regarding New Jersey premium, loss costs, loss and loss adjustment expenses. Data shall be by coverage for the latest three calendar-accident years, or fiscal-accident years, at either total limits or basic limits, where applicable. Filers shall provide all underlying calculations and justifications for any factors used:

See: 25 N.J.R. 4523(a).
 Amended by R.1994 d.46, effective January 18, 1994.
 See: 25 N.J.R. 4436(a), 26 N.J.R. 378(b).
 Amended by R.1998 d.128, effective March 2, 1998.
 See: 29 N.J.R. 5240(a), 30 N.J.R. 828(a).
 In (a), added a second sentence in 1; in (f), added a reference to loss costs at the end; and added (g) through (i).
 Amended by R.2001 d.44, effective February 5, 2001.
 See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).
 Rewrote the section.
 Amended by R.2003 d.173, effective May 5, 2003.
 See: 34 N.J.R. 3475(a), 35 N.J.R. 1907(a).
 Rewrote (a) and (b).
 Amended by R.2003 d.499, effective December 15, 2003.
 See: 35 N.J.R. 3084(b), 35 N.J.R. 5604(a).
 Rewrote the section.
 Repeal and New Rule, R.2005 d.176, effective June 6, 2005.
 See: 36 N.J.R. 5640(a), 37 N.J.R. 2026(a).
 Section was "Rate calculation using standard ratemaking methodology".

11:3-16.11 Incomplete filings and further proceedings

(a) Failure to submit the data and calculations required by this subchapter may result in a finding that the filing is incomplete. The Department shall promptly notify a filer of a finding that its filing is incomplete.

(b) No finding that a filing is incomplete shall be based solely on the filer's failure to include data that was either not being collected, or was not collected in a manner so as to facilitate reporting, on February 5, 1990, provided that the filer includes with the filing a statement that identifies the item or items not included; specifies the reason; and certifies that the filer is undertaking action to collect and report such data in the future pursuant to N.J.A.C. 11:3-16.3(a).

(c) For informational filings, failure to submit a filing or failure to cure the deficiency of an incomplete filing within 30 days of notice shall authorize the Department to impose penalties as provided by N.J.S.A. 17:29A-23. Any penalty imposed shall be in addition to penalties imposed for failure to file an Excess Profits Report.

(d) For filings requiring prior approval, a notice that the filing is incomplete shall include a statement that the filing is disapproved as a nonconforming filing. The filer may thereafter resubmit the filing for approval with the deficiencies cured as noted.

Recodified from N.J.A.C. 11:3-16.11, effective November 26, 1990 (expired January 25, 1991).

See: 22 N.J.R. 3790(a).
 Recodification adopted effective January 25, 1991.
 See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
 Amended by R.2001 d.44, effective February 5, 2001.
 See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

Deleted former (d) and recodified (e) as (d).
 Recodified from N.J.A.C. 11:3-16.13 by R.2005 d.176, effective June 6, 2005.

See: 36 N.J.R. 5640(a), 37 N.J.R. 2026(a).
 Former N.J.A.C. 11:3-16.11, Rate filings reflecting assessments and surtaxes, repealed.

Case Notes

Documents were not protected from disclosure under the deliberative process privilege. In the Matter of the Commissioner of Insurance's

December 29, 1992 Certification of Amendments, 94 N.J.A.R.2d (INS) 31.

11:3-16.12 (Reserved)

New Rule, R.1998 d.128, effective March 2, 1998.
 See: 29 N.J.R. 5240(a), 30 N.J.R. 828(a).
 Amended by R.2001 d.44, effective February 5, 2001.
 See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).
 In (a), amended the N.J.A.C. reference.
 Amended by R.2003 d.95, effective March 3, 2003.
 See: 34 N.J.R. 3470(a), 35 N.J.R. 1289(a).
 In (a), deleted "as of December 31 of the prior year" following "policies written"; rewrote (b).
 Recodified from N.J.A.C. 11:3-16.15 and amended by R.2005 d.176, effective June 6, 2005.
 See: 36 N.J.R. 5640(a), 37 N.J.R. 2026(a).
 Deleted (c). Former N.J.A.C. 11:3-16.12, was reserved.
 Repealed by R.2011 d.165, effective June 6, 2011.
 See: 42 N.J.R. 2700(a), 43 N.J.R. 1352(a).
 Section was "Voluntary written exposure and primary classification data".

11:3-16.13 Prospective loss cost filing requirements for insurers

(a) In order for an insurer to incorporate a rating organization's prospective loss costs to establish its own rates, an insurer shall:

1. Be a participating insurer in the rating organization; and

2. File its loss cost multiplier using the Reference Filing Adoption Form (as set forth in Appendix Exhibit C to this subchapter and incorporated herein by reference). An insurer's loss cost multiplier shall be filed and become effective in accordance with N.J.S.A. 17:29A-1 et seq., N.J.S.A. 17:33B-31, and applicable provisions of N.J.A.C. 11:3-16 and 18. An insurer's final rates shall be a combination of the prospective loss costs and the loss cost multiplier.

- i. An insurer may file modifications to the rating organization's approved prospective loss cost filing based on its own anticipated experience by using the Reference Filing Adoption Form. Supporting documentation shall be filed for any modification (upwards or downwards) to the rating organization's prospective loss cost filings. Supporting documentation must comply with N.J.A.C. 11:3-16.3(k).

- ii. An insurer's loss cost multiplier shall remain in effect until the insurer revises the multiplier in accordance with N.J.S.A. 17:29A-14 and applicable provisions of N.J.A.C. 11:3-16 and 18.

(b) An insurer may vary expense loads by coverage. An insurer may use variable or fixed expense loads or a combination of these to establish their expense loadings by using the Reference Filing Adoption Form. An insurer's loss cost multiplier based on its expenses plus any profit provision shall be developed in accordance with N.J.A.C. 11:3-16.3(l).

(c) Any insurer participating in a rating organization shall continue to use all rates and deviations currently in effect for its use, until disapproved pursuant to N.J.S.A. 17:29A-14 or until the insurer revises its rates, either by making an independent filing or by filing a Reference Filing Adoption Form.

New Rule, R.1998 d.128, effective March 2, 1998.
See: 29 N.J.R. 5240(a), 30 N.J.R. 828(a).
Recodified from N.J.A.C. 11:3-16.16 and amended by R.2005 d.176, effective June 6, 2005.
See: 36 N.J.R. 5640(a), 37 N.J.R. 2026(a).
In (a), substituted "Appendix exhibit D" for "Appendix exhibit C" in 2. Former N.J.A.C. 11:3-16.13, Incomplete filings and further proceedings, recodified to N.J.A.C. 11:3-16.11.

11:3-16.14 (Reserved)

Emergency New Rule, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Provision of emergency amendment, R.1990 d.621, readopted without change.

Repealed by R.2005 d.176, effective June 6, 2005.
See: 36 N.J.R. 5640(a), 37 N.J.R. 2026(a).
Section was "Rate adjustments upon repayment of assessments".

Case Notes

Act's provision requiring assessments to be deposited in guaranty fund was not unconstitutional. Matter of Loans of New Jersey Property Liability Ins. Guar. Ass'n, 124 N.J. 69, 590 A.2d 210, (1991).

11:3-16.15 (Reserved)

Recodified to N.J.A.C. 11:3-16.12 by R.2005 d.176, effective June 6, 2005.
See: 36 N.J.R. 5640(a), 37 N.J.R. 2026(a).
Former N.J.A.C. 11:3-16.15, Voluntary written exposure and primary classification data, recodified to N.J.A.C. 11:3-16.12.

11:3-16.16 (Reserved)

Recodified to N.J.A.C. 11:3-16.13 by R.2005 d.176, effective June 6, 2005.
See: 36 N.J.R. 5640(a), 37 N.J.R. 2026(a).
Former N.J.A.C. 11:3-16.16, Prospective loss cost filing requirements for insurers, recodified to N.J.A.C. 11:3-16.13.

APPENDIX

EXHIBIT A

PRIOR APPROVAL FILINGS

Company/Group: _____

Company File No.: _____

Section	Item	Page #
1)	Filing Requirements	
16.3(d)	Filing Source Document MARS001	Yes / No
16.3(e)	Certification of compliance (exact text in regulation) signed by officer	Yes / No
16.3(f)	All data reported on direct basis exclusive of reinsurance	Yes / No
16.3(g)	All data from voluntary market only	Yes / No
16.6(a)1	Cover letter including proposed revision, effective date, and company contact information	_____
16.6(a)2	This checklist	Yes / No
16.6(a)3	Appendix Exhibit B	Yes / No
16.6(a)4	Narrative overview	Yes / No
16.6(a)8	Proposed rates (or loss costs) for each territory and coverage together with their derivation.	_____
16.6(a)9	Calculation demonstrating compliance with NJSA 17:29A-36	_____
16.6(a)10	Rating examples in accordance with NJAC 11:3-45	_____
16.6(a)11	Data disk or CD-ROM in MS Excel 97 format	Yes / No

2) Premium, Loss, and LAE Data—All data must be at total limits and/or basic limits and must be consistent throughout the filing. All data is to be provided by coverage by accident year for each of the latest three years.

16.8(a)1	NJ direct earned premium (or loss cost) at present rates with supporting documentation	_____
16.8(a)2	Premium trend exhibits	_____
16.8(a)3	NJ direct earned exposures	_____
16.8(a)4	NJ direct paid or incurred losses	_____
16.8(a)5	NJ direct paid or incurred D & CC LAE	_____
16.8(a)6	NJ direct paid or incurred A & O LAE	_____
16.8(a)7	Ultimate developed loss and LAE	_____
16.8(a)8	NJ direct paid or incurred claim counts	_____
16.8(a)9	Ultimate developed claim counts	_____
16.8(a)10	Loss trend exhibits	_____
16.8(a)11	Trended ultimate developed loss and LAE	_____
16.8(b)	(Required only if losses are separated into catastrophe and non-catastrophe)	_____
	· Clear description and justification of the standard used	_____
	· At least 10 years used to determine catastrophe load	_____
	· Explanation if database used for catastrophe load is different from that used for rate level change	_____
16.8(c)	(Required only if territorial factors are changing)	_____
	· Territorial rate indications	_____
16.8(d)	(Required only if classification factors are changing)	_____
	· Differentials and loss ratios by class	_____
16.8(e)	(Required only if tier relativities are changing)	_____
	· Differentials and loss ratios by tier	_____
16.8(f)	Credibility exhibits	_____

3) Expense Data

16.9(a)1	Selected expense provisions and related information	_____
16.9(a)2i	Commission and Brokerage expenses from NJ Page 14	_____
16.9(a)2ii	Other acquisition expenses from IEE	_____
16.9(a)2iii	General expenses from IEE	_____
16.9(a)2iv	Taxes, Licenses, and Fees expenses from NJ Page 14	_____
16.9(a)3i	Finance and other miscellaneous charges	_____
16.9(a)3ii	Description of affiliated-company transactions	_____
16.9(b)	Expense flattening per NJSA 17:29A-37	_____
16.9(c)	Expenses Capped by Appendix Exhibit E Calculation (available on DOBI website)	Yes / No
16.9(d)	Excluded Expenses (state if none)	_____
16.9(e)	Bodily Injury Liability Commissions equalized using Appendix Exhibit C	_____
16.9(f)	Expense data on direct basis	Yes / No

4) Profit and contingency provision

16.10(a)	Profit and contingency provision does not result in rates that are excessive, inadequate, or unfairly discriminatory	_____
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New Rule, R.2003 d.173, effective May 5, 2003.
 See: 34 N.J.R. 3475(a), 35 N.J.R. 1907(a).
 Amended by R.2003 d.499, effective December 15, 2003.
 See: 35 N.J.R. 3084(a), 35 N.J.R. 5604(a).

Repeal and New Rule, R.2005 d.176, effective June 6, 2005.
 See: 36 N.J.R. 5640(a), 37 N.J.R. 2026(a).

In 5), deleted "PIP losses capped at \$ 75,000"; in 6), deleted "PIP losses limited to \$ 75,000"; in 11), substituted "ROE formula" for "Clifford Formula" in 16.10(a)1; rewrote 12).

EXHIBIT B

	Percentage Change	Dollar Effect	Latest Year Earned Exposures	Latest Year On-Level Earned Premium
Bodily Injury				
Limitation				
No Limitation				
Property Damage				
Personal Injury Protection				
Uninsured Motorists				
Limitation				
No Limitation				
Total Liability				
Comprehensive				
Collision				
Total Physical Damage				
Overall Total				
	Current	Proposed	Percentage Change	Dollar Effect
Expense Fees				
Single Limit Liability				
Bodily Injury				
Property Damage				
Personal Injury Protection				
Comprehensive				
Collision				

Emergency Repeal and Replacement, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
 See: 22 N.J.R. 3790(a).
 Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
 See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
 Repeal and Replacement, R.1990 d.621, readopted with changes effective February 19, 1991.
 Amended by R.2003 d.173, effective May 5, 2003.
 See: 34 N.J.R. 3475(a), 35 N.J.R. 1907(a).

Inserted "Latest Year Earned Exposures" and "Latest Year On-Level Earned Premium" and inserted "Add columns for latest year earned exposures and latest year on-level earned premium by coverage".
 Recodified from N.J.A.C. 11:3-16 Appendix Exhibit E and amended by R.2005 d.176, effective June 6, 2005.
 See: 36 N.J.R. 5640(a), 37 N.J.R. 2026(a).
 Rewrote the section.

EXHIBIT C

Worksheet to Determine No Limitation on Lawsuit
 Premium and Commission for BI and UMBI

Insurance Group Name _____

Insurance Company Name _____

Group NAIC Number _____

Company NAIC Number _____

BEFORE COMPLETING THIS FORM, PLEASE READ THE INSTRUCTIONS FOLLOWING SECTION D.

Section A

Section A develops the revised Limitation on Lawsuit base rate after the rate change.

patient who has received trauma care is discharged from acute care.

Amended by R.1992 d.170, effective April 6, 1992.

See: 23 N.J.R. 3203(a), 24 N.J.R. 1347(a).

Definition for eligible charge added.

Amended by R.1993 d.25, effective January 4, 1993.

See: 24 N.J.R. 3605(a), 25 N.J.R. 140(a).

Definitions for motor bus, motor bus insurer added.

Amended by R.1993 d.395, effective August 2, 1993.

See: 25 N.J.R. 229(b), 25 N.J.R. 3466(b).

Amended by R.1994 d.564, effective November 21, 1994 (operative January 1, 1995).

See: 25 N.J.R. 4706(a), 26 N.J.R. 4616(b).

Amended by R.2001 d.158, effective May 21, 2001.

See: 32 N.J.R. 4332(a), 33 N.J.R. 226(a), 33 N.J.R. 1590(a).

Added "Bilateral surgery", "Emergency care", "Health care provider", "Medically necessary" and "Three-digit zip code"; rewrote "CPT"; changed "Eligible charge" to "Eligible charge or expense"; changed "Global charge" to "Global service"; in "Health insurance", substituted "disability" for "disablement" following "the bodily injury"; in PIP coverage, amended the N.J.S.A. references; deleted "Provider".

Amended by R.2003 d.143, effective April 7, 2003.

See: 34 N.J.R. 1237(a), 35 N.J.R. 1547(b).

Added "CDT-3".

Amended by R.2007 d.305, effective October 1, 2007.

See: 38 N.J.R. 3437(a), 39 N.J.R. 4126(c).

Added definitions "Ambulatory surgery facility" or "ASC", "Ambulatory surgical case", "Co-surgery", "Modifier", "Multiple surgeries", and "Powered traction device"; in definition "CPT", inserted "Version 2006" and inserted the second through sixth sentences; and in definition "HCPCS", substituted "Center for Medicare and Medicaid Services (CMS)" for "Health Care Financing Administration's (HCFA's)".

Notice of Stay of Implementation: See: 39 N.J.R. 4849(a).

By Order of the Appellate Division of the Superior Court of New Jersey entered on September 28, 2007, the implementation of amendments to this rule published in the October 1, 2007 New Jersey Register at 39 N.J.R. 4126(c) was stayed pending a decision in the matter of *Alliance for Quality Care, Inc., et al. v. New Jersey Department of Banking and Insurance*, Docket No. A33-07 T3, now pending before the Appellate Division.

Amended by R.2012 d.187, effective November 5, 2012 (operative January 4, 2013).

See: 43 N.J.R. 1640(a), 44 N.J.R. 383(a), 44 N.J.R. 2652(c).

Substituted definition "CDT" for definition "CDT-3"; in definition "CDT", substituted "2011-2012, copyright 2010" for "Third Edition, Version 2000"; in definition "CPT", substituted the first occurrence of "2011" for "2006" and the second occurrence of "2011" for "2005"; in definition "Eligible charge or expense", deleted "provider's" preceding "usual", and inserted "as determined pursuant to N.J.A.C. 11:3-29.4(e)1"; and added definitions "Hospital", "Hospital outpatient", "Hospital outpatient surgical facility" or "HOSF" and "Trauma services".

11:3-29.3 Regions

(a) The Regions in Appendix, Exhibit 1, Physicians' Fee Schedule, Exhibit 2, Dental Fee Schedule and Exhibit 4, Ambulance Services, are as follows:

1. South Region consists of Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Monmouth, Ocean and Salem counties, which are comprised of the following three- and five-digit zip codes in New Jersey: 077, 080, 081, 082, 083, 084, 086 and 087. The South Region also includes: 08501, 08505, 08510, 08511, 08514 through 08527, 08533 through 08535, 08540 through 08550, 08554, 08555 and 08560 through 08562.

2. North Region consists of Bergen, Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic, Somerset, Sussex, Union and Warren counties, which are comprised of the following three- and five-digit zip codes in New Jersey: 070, 071, 072, 073, 074, 075, 076, 078, 079, 088 and 089. The North Region also includes: 08502, 08504, 08512, 08528, 08530, 08536, 08551, 08553, 08556 through 08559 and 08570.

Amended by R.2001 d.253, effective July 16, 2001.

See: 32 N.J.R. 4332(a), 33 N.J.R. 226(a), 33 N.J.R. 2507(a).

Rewrote the section.

Amended by R.2007 d.305, effective October 1, 2007.

See: 38 N.J.R. 3437(a), 39 N.J.R. 4126(c).

Added the introductory paragraph of (a); recodified former (a) as (a)1; recodified former (b) as (a)2; rewrote (a)1 and (a)2; added new (b); and deleted (c).

Notice of Stay of Implementation: See: 39 N.J.R. 4849(a).

By Order of the Appellate Division of the Superior Court of New Jersey entered on September 28, 2007, the implementation of amendments to this rule published in the October 1, 2007 New Jersey Register at 39 N.J.R. 4126(c) was stayed pending a decision in the matter of *Alliance for Quality Care, Inc., et al. v. New Jersey Department of Banking and Insurance*, Docket No. A33-07 T3, now pending before the Appellate Division.

Amended by R.2012 d.187, effective November 5, 2012 (operative January 4, 2013).

See: 43 N.J.R. 1640(a), 44 N.J.R. 2652(c).

In the introductory paragraph of (a), inserted "Exhibit 2, Dental Fee Schedule and", and substituted "Services" for "Fee Schedule, and Exhibit 7, Ambulatory Surgical Center Fee Schedule"; and deleted (b).

11:3-29.4 Application of medical fee schedules

(a) Nothing in this subchapter shall compel the PIP insurer or a motor bus insurer to pay more for any service or equipment than the usual, customary and reasonable fee, even if such fee is well below the automobile insurer's or motor bus insurer's limit of liability as set forth in the fee schedules. Insurers are not required to pay for services or equipment that are not medically necessary.

1. The fees for physicians' services in subchapter Appendix, Exhibit 1, the provisions in (f)1 through 7 below and the non-physician facility fees in subchapter Appendix, Exhibit 7 shall not apply to trauma services at Level I and Level II trauma hospitals. Bills for services subject to the trauma services exemption shall use the modifier "-TS".

2. The non-physician facility fees in subchapter Appendix, Exhibit 7 shall not apply to services provided in hospital emergency rooms. The bills for these services shall use the modifier "-ER".

3. The physician fees for surgical services (CPT 10000 through 69999) provided in emergency care in acute care hospitals that are not subject to the trauma care exemption shall be reimbursed at 150 percent of the physicians' fees in subchapter Appendix, Exhibit 1. The bills for these services shall use the modifier "-ER".

4. Except as provided in (a)1 through 3 above, the fees in Appendix, Exhibits 1 through 7 apply regardless of the site of service.

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

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

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

2. For the provision and billing of durable medical equipment, payors shall follow the relevant provisions of Chapter 20 of the Medicare Claims Processing Manual, updated periodically by CMS and incorporated by reference, that were in effect at the time the service was provided (<http://www.cms.gov/manuals/downloads/clm104c20.pdf>).

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

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

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

(e) Except as noted in (e)1 through 3 below, the insurer's limit of liability for any medical expense benefit for any service or equipment not set forth in or not covered by the fee schedules shall be a reasonable amount considering the fee schedule amount for similar services or equipment in the region where the service or equipment was provided or, in the case of elective services or equipment provided outside the State, the region in which the insured resides. When a CPT, CDT or HCPCS code for the service performed has been changed since the fee schedule rule was last amended, the provider shall always bill the actual and correct code found in the most recent version of the American Medical Association's Current Procedural Terminology or the American Dental Association's Current Dental Terminology. The amount that the insurer pays for the service shall be in accordance with this subsection. Where the fee schedule does not contain a reference to similar services or equipment as set forth in the

preceding sentence, the insurer's limit of liability for any medical expense benefit for any service or equipment not set forth in the fee schedules shall not exceed the usual, customary and reasonable fee.

1. For the purposes of this subchapter, determination of the usual, reasonable and customary fee means that the provider submits to the insurer his or her usual and customary fee by means of explanations of benefits from payors showing the provider's billed and paid fee(s). The insurer determines the reasonableness of the provider's fee by comparison of its experience with that provider and with other providers in the region. National databases of fees, such as those published by Ingenix (www.ingenixonline.com), FAIR Health (www.fairhealthus.org) or Wasserman (<http://www.medfees.com/>), for example, are evidence of the reasonableness of fees for the provider's geographic region or zip code. The use of national databases of fees is not limited to the above examples. When using a database as evidence of the reasonableness of a fee, the insurer shall identify the database used, the edition date, the geozip and the percentile.

2. All applicable provisions of this section concerning billing and payment apply to fees for services provided outside of New Jersey and to fees that are not on the fee schedule.

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

(f) Except as specifically stated to the contrary, the following shall apply to physician charges for multiple and bilateral surgeries (CPT 10000 through 69999), co-surgeries and assistant surgeons:

1. For multiple surgeries, rank the surgical procedures in descending order by the fee amount, using the fee schedule or UCR amount, as appropriate. The highest valued procedure is reimbursed at 100 percent of the eligible charge. Additional procedures are reported with the modifier "-51" and are reimbursed at 50 percent of the eligible charge. If any of the multiple surgeries are bilateral surgeries using the modifier "-50," consider the bilateral procedure at 150 percent as one payment amount, rank this with the remaining procedures, and apply the appropriate multiple surgery reductions.

2. There are two types of procedures that are exempt from the multiple procedure reduction. Codes in CPT that have the note, "Modifier -51 exempt" shall be reimbursed at 100 percent of the eligible charge. In addition, some related procedures are commonly carried out in addition to the primary procedure. These procedure codes contain a specific descriptor that includes the words, "each additional" or "list separately in addition to the primary procedure." These add-on codes cannot be reported as stand-

(l) Certain CPT codes are listed in the fee schedule with three entries. There is a global fee with no modifier, a technical component with modifier "TC" and a physician component with modifier "-26". Services with physician component amounts of zero in the fee schedule are considered to be 100 percent technical. A provider shall not bill the global fee and a technical or physician component. The technical or physician component shall be billed when only that part of the service is being provided.

(m) The daily maximum allowable fee shall be \$105.00 for the Physical Medicine and Rehabilitation CPT codes listed in subchapter Appendix, Exhibit 6, incorporated herein by reference, that are commonly provided together. The daily maximum applies when such services are performed for the same patient on the same date. In determining whether a provider has reached the daily maximum, the insurer shall apply the NCCI edits. The daily maximum applies to all providers, including dentists. However, when the provider can demonstrate that the severity or extent of the injury is such that extraordinary time and effort is needed for effective treatment, the insurer shall reimburse in excess of the daily maximum. Such injuries could include, but are not limited to, severe brain injury and non-soft-tissue injuries to more than one part of the body. Such injuries would not include diagnoses for which there are care paths in N.J.A.C. 11:3-4. Treatment that the provider believes should not be subject to the daily maximum shall be billed using modifier -22 as designated in CPT for unusual procedural services. Unless already provided to the insurer as part of a decision point review or precertification request, the billing shall be accompanied by documentation of why the extraordinary time and effort for treatment was needed.

1. Supervised modalities and those therapeutic procedures that do not list a specific time increment in their description shall be limited to one unit per day.
2. CPT 97012 is the appropriate code for billing powered traction therapy.
3. CPT 97026 is the appropriate code for billing cold or low-powered laser therapy.
4. HPCPS code G0283 is the appropriate code for billing unattended electrical stimulation.
5. Pursuant to N.J.S.A. 39:6A-4, physical therapy, as defined in N.J.S.A. 45:9-37.13, shall not be reimbursable under PIP unless rendered by a licensed physical therapist pursuant to a referral from a licensed physician, dentist, podiatrist or chiropractor within the scope of the respective practices.

(n) Follow-up evaluation and management services for the re-examination of an established patient shall be reimbursed in addition to physical medicine and rehabilitation procedures only when any of the circumstances set forth in (n)1 through 4 below is present and not more than twice in any 30-day period. Modifier -25 shall be added to an evaluation and

management service when a significant separately identifiable evaluation and management service is provided and documented as medically necessary as follows:

1. There is a definite measurable change in the patient's condition requiring significant change in the treatment plan;
2. The patient fails to respond to treatment, requiring a change in the treatment plan;
3. The patient's condition becomes permanent and stationary, or the patient is ready for discharge; or
4. It is medically necessary to provide evaluation services over and above those normally provided during the therapeutic services.

(o) Regardless of the specific codes that are included in a DPR/Precertification request, the insurer's reimbursement for those services shall be consistent with the rules contained in this subchapter, including the NCCI edits and the CPT Manual current at the time the services were provided.

(p) The ANES code on the Physicians' Fee Schedule is the conversion factor for anesthesia units. Payors shall follow the Medicare Claims Processing Manual and other guidelines for calculating the number of units for the various CPT codes for the administration of anesthesia and other billing situations, such as directing or supervising Certified Nurse Anesthetists and other non-physician anesthesia providers. These can be found at: www.cms.hhs.gov/center/anesth.asp.

Amended by R.1992 d.170, effective April 6, 1992.
See: 23 N.J.R. 3203(a), 24 N.J.R. 1347(a).

Billing for multiple procedures clarified in (f).
Amended by R.1993 d.25, effective January 4, 1993.
See: 24 N.J.R. 3605(a), 25 N.J.R. 140(a).

Motor bus insurers added.
Amended by R.1993 d.395, effective August 2, 1993.
See: 25 N.J.R. 229(b), 25 N.J.R. 3466(b).
Amended by R.1994 d.564, effective November 21, 1994 (operative January 1, 1995).
See: 25 N.J.R. 4706(a), 26 N.J.R. 4616(b).
Administrative Correction to (a).
See: 26 N.J.R. 5041(a).
Amended by R.2001 d.158, effective May 21, 2001.
See: 32 N.J.R. 4332(a), 33 N.J.R. 226(a), 33 N.J.R. 1590(a).

Rewrote the section.
Amended by R.2001 d.253, effective July 16, 2001.
See: 32 N.J.R. 4332(a), 33 N.J.R. 226(a), 33 N.J.R. 2507(a).

Rewrote (a); in (c), rewrote the introductory paragraph and inserted "new equipment" preceding "purchase price" in 1.
Amended by R.2003 d.143, effective April 7, 2003.
See: 34 N.J.R. 1237(a), 35 N.J.R. 1547(b).

Rewrote (c), (i) and (m).
Amended by R.2007 d.305, effective October 1, 2007.
See: 38 N.J.R. 3437(a), 39 N.J.R. 4126(c).

Rewrote (a); in (c)1, inserted "or the purchase price of the item, whichever is less"; in the introductory paragraph of (e), substituted "Except as noted in (e)1 and 2 below, the" for "The"; added (e)1 and (e)2; rewrote the introductory paragraph of (f) and (f)1 through (f)4; added (f)5 through (f)7; rewrote the introductory paragraph of (g); added (g)1 through (g)6; added new (h) and (i); recodified former (h) and (i) as (j) and (k); rewrote (k); deleted former (j) and (k); rewrote (l) and (m); recodified former (n) as (m)1; added (m)2 through (m)5; recodified former (o) as (n); and added new (o), (p) and (q).
Notice of Stay of Implementation: See: 39 N.J.R. 4849(a).

By Order of the Appellate Division of the Superior Court of New Jersey entered on September 28, 2007, the implementation of amendments to this rule published in the October 1, 2007 New Jersey Register at 39 N.J.R. 4126(c) was stayed pending a decision in the matter of *Alliance for Quality Care, Inc., et al. v. New Jersey Department of Banking and Insurance*, Docket No. A33-07 T3, now pending before the Appellate Division.

Amended by R.2012 d.187, effective November 5, 2012 (operative January 4, 2013).

See: 43 N.J.R. 1640(a), 44 N.J.R. 383(a), 44 N.J.R. 2652(c).

Rewrote the section.

Case Notes

A medical equipment supplier was a "medical institution" which was subject to the pricing and disclosure provisions of the No Fault Act and its regulations; thus an automobile insurer need not pay more than the scheduled fees or the provider's usual, customary, and reasonable fee and was entitled to information on the cost of products. *Allstate Insurance Co. v. A & A Medical Supplies*, 330 N.J.Super. 360, 749 A.2d 890 (N.J.Super.L. 1999).

No-fault insurer should have been allowed to adjust insured's medical bills to reflect relevant medical fee schedule. *Leeman v. Eagle Ins. Co.*, 707 A.2d 1037, 309 N.J.Super. 525.

Under Commissioner of Insurance's medical fee regulations allowing physical therapists to bill personal injury protection claimants according to modality, rather than charging flat rate fee, rates charged had to be consistent with the therapists' customary rates in order to be considered reasonable; remand. *Cobo by Hudson Physical Therapy Services v. Market Transition Facility by Material Damage Adjustment Corp.*, 293 N.J.Super. 374, 680 A.2d 1103 (A.D.1996).

Former patient failed to establish that charges reflected in bill were not usual, customary, and reasonable; hospital's witness testified that charges were in accord with other teaching institutions in area and were approved by state insurance commission, and patient's insurance company paid its full share of all charges and did not reject any by claiming that they were not usual, customary, reasonable, and/or necessary. *Hahnemann University Hosp. v. Dudnick*, 292 N.J.Super. 11, 678 A.2d 266 (A.D.1996).

Examination fees were not reasonable despite being consistent with prevailing rates. *Thermographic Diagnostics, Inc. v. Allstate Ins. Co.*, 125 N.J. 491, 593 A.2d 768 (1991).

Agency-promulgated schedule of fees was pertinent to reasonableness of fees charged. *Thermographic Diagnostics, Inc. v. Allstate Ins. Co.*, 125 N.J. 491, 593 A.2d 768 (1991).

11:3-29.5 ASC facility fees; hospital outpatient surgical facility fees

(a) 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. The ASC facility fees include services that would be covered if the services were furnished in a hospital on an inpatient or outpatient basis, including:

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

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

3. Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment;

4. Diagnostic and therapeutic items and services. Appendix, Exhibit 1 indicates those CPT codes that, according to Medicare (see: www.cms.gov/ASCPayment/ASCRN/list.asp, CMS-1504-FC, Exhibit AA) are considered ancillary services that are integral to surgical procedures and are not permitted to be reimbursed separately in an ASC. Appendix, Exhibit 7 indicates those services that, according to Medicare (see: https://www.cms.gov/HospitalOutpatientPPS/Downloads/CMS1506FC_Addendum_D1.pdf) are considered ancillary services to surgical procedures and are not permitted to be reimbursed separately in a HOSF;

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

6. Blood, blood plasma, platelets, etc.;

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

8. Implantable DME and prosthetics.

(b) HOSF fees are listed on subchapter Appendix, Exhibit 7 by CPT code. The hospital outpatient surgical facility fee is the maximum that can be reimbursed for outpatient procedures performed in an HOSF. The hospital outpatient facility fees in Appendix Exhibit 7 include services that would be covered if furnished in a hospital on an inpatient basis, including those set forth in (a)1 through 8 above.

(c) The sale, lease or rental of durable medical equipment (DME) to patients for use in their homes are not included in the ASC or HOSF fee. If the ASC or HOSF furnishes items of DME to patients, billing for such items should be made in accordance with subchapter Appendix, Exhibit 5.

(d) When multiple procedures are performed in an ASC or in an HOSF in the same operative session, the ASC facility fee or the HOSF fee, as applicable, for the procedure with the highest payment amount is reimbursed at 100 percent and reimbursement of any additional procedures furnished in the same session is 50 percent of the applicable facility fee.

1. A procedure performed bilaterally in one operative session is reported as two procedures and is subject to the multiple procedure reduction formula.

2. Subchapter Appendices, Exhibit 1, the Physicians' and ASC Facility Fee Schedule and Exhibit 7, the HOSF fee schedule, indicate those CPT codes that, according to Medicare (see: www.cms.gov/ASCPayment/ASCRN/list.asp and <http://www.cms.gov/HospitalOutpatientPPS/>) are exempt from the multiple procedure reduction formula.

New Rule, R.2012 d.187, effective November 5, 2012 (operative January 4, 2013).

See: 43 N.J.R. 1640(a), 44 N.J.R. 383(a), 44 N.J.R. 2652(c).

Former N.J.A.C. 11:3-29.5, Balance billing prohibited, recodified to N.J.A.C. 11:3-29.6.

11:3-29.6 Balance billing prohibited

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

Amended by R.2001 d.158, effective May 21, 2001.

See: 32 N.J.R. 4332(a), 33 N.J.R. 226(a), 33 N.J.R. 1590(a).

Substituted "that" for "which" following "amount of money" and inserted "and this subchapter" following "medical fee schedules" throughout.

Recodified from N.J.A.C. 11:3-29.5 by R.2012 d.187, effective November 5, 2012 (operative January 4, 2013).

See: 43 N.J.R. 1640(a), 44 N.J.R. 383(a), 44 N.J.R. 2652(c).

Section was "Reserved".

APPENDIX

Exhibit 1

Physicians' & Ambulatory Surgical Center (ASC) Facility Fee Schedule

CPT* HCPS	MOD	DESCRIPTION	Physicians' Fees North	Physicians' Fees South	ASC Fees North	ASC Fees South	Payment Indicator (See bottom for codes)
*Current Procedural Terminology (CPT) is copyright 2010 American Medical Association (AMA). All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. CPT® is a trademark of the American Medical Association.							
Anes		ANESTHESIA BASE UNITS	86.47	84.36			
0232T		NJX PLATELET PLASMA	63.95	63.95	89.55	82.44	X
G0283		ELECTRICAL STIMULATION, (UNATTENDED), TO ONE OR MORE AREAS,	20.14	19.26			
G0289		ARTHRO, LOOSE BODY + CHONDRO	483.50	467.07			X, N1
10060		DRAIN SKIN ABSCESS	176.46	168.00	198.84	183.03	
10061		DRAIN SKIN ABSCESS	290.74	278.25	198.84	183.03	
10120		REMOVE FOREIGN BODY	219.66	208.52	297.15	273.51	
10121		REMOVE FOREIGN BODY	423.57	403.23	2,411.70	2,219.85	
10140		DRAIN HEMATOMA/FLUID	250.71	238.43	321.75	296.13	
10160		PUNCTURE DRAIN LESION	203.36	193.31	198.84	183.03	
10180		COMPLEX DRAIN WOUND	381.01	362.70	2,694.69	2,480.34	
11000		DEBRIDE INFECTED SKIN	84.28	80.26	102.96	94.77	
11001		DEBRIDE INFECTED SKIN, ADDED	33.67	32.24	33.93	31.23	
11010		DEBRIDE SKIN, FX	770.97	732.08	678.84	624.84	
11011		DEBRIDE SKIN/MUSCLE, FX	842.60	801.49	678.84	624.84	
11012		DEBRIDE SKIN/MUSCLE/BONE, FX	1,128.89	1,074.42	678.84	624.84	
11042		DEBRIDE SKIN/TISSUE	141.88	134.65	364.44	335.43	
11043		DEBRIDE TISSUE/MUSCLE	309.64	294.89	364.44	335.43	
11044		DEBRIDE TISSUE/MUSCLE/BONE	467.58	447.17	1,132.98	1,042.83	
11045		DEBRIDE SUBQ TISSUE ADD-ON	50.08	47.78	364.44	335.43	
11046		DEBRIDE MUSCLE/FASCIA ADD-ON	86.02	82.37	364.44	335.43	
11047		DEBRIDE BONE ADD-ON	141.04	135.27	1,132.98	1,042.83	
11055		TRIM SKIN LESION	78.70	74.56	111.15	102.30	
11056		TRIM SKIN LESIONS, 2 TO 4	93.59	88.93	121.44	111.78	
11057		TRIM SKIN LESIONS, OVER 4	110.23	104.93	121.44	111.78	
11100		BIOPSY SKIN LESION	168.53	159.57	199.77	183.90	
11101		BIOPSY SKIN, ADDED	52.52	50.16	58.50	53.85	
11200		REMOVE SKIN TAGS	136.42	129.65	121.44	111.78	
11300		SHAVE SKIN LESION	111.63	105.61	121.44	111.78	
11301		SHAVE SKIN LESION	150.18	142.55	121.44	111.78	
11302		SHAVE SKIN LESION	179.35	170.36	121.44	111.78	
11305		SHAVE SKIN LESION	110.55	104.93	121.44	111.78	
11306		SHAVE SKIN LESION	152.62	145.18	121.44	111.78	
11310		SHAVE SKIN LESION	137.16	130.09	121.44	111.78	
11311		SHAVE SKIN LESION	171.78	163.30	121.44	111.78	
11400		EXCISE TRT-EXT BENIGN+MARG 0.5 < CM	192.83	182.50	283.11	260.58	
11401		EXCISE TRT-EXT BENIGN+MARG 0.6-1 CM	234.32	222.41	319.41	294.00	
11402		EXCISE TRT-EXT BENIGN+MARG 1.1-2 CM	260.75	247.62	350.97	323.04	
11403		EXCISE TRT-EXT BENIGN+MARG 2.1-3 CM	298.16	283.70	379.02	348.87	
11404		EXCISE TRT-EXT BENIGN+MARG 3.1-4 CM	338.86	322.54	2,411.70	2,219.85	
11406		EXCISE TRT-EXT BENIGN+MARG > 4.0 CM	478.41	457.22	2,411.70	2,219.85	
11420		EXCISE H-F-NECK-SP BENIGN+MARG 0.5 <	191.28	181.36	266.76	245.52	

CPT* HCPS	MOD	DESCRIPTION	Physicians' Fees North	Physicians' Fees South	ASC Fees North	ASC Fees South	Payment Indicator (See bottom for codes)
15260		SKIN FULL GRAFT EEN & LIPS	1,614.97	1,541.12	2,296.11	2,113.44	
15330		APPLY ACELLULAR ALLOGRAFT T/ARM/LEG	513.93	491.81	619.29	570.03	
15331		APPLY ACELLULAR GRAFT T/A/L, ADDED	100.16	96.58	619.29	570.03	
15340		APPLY CULT SKIN SUBSTITUTE	497.48	475.21	421.80	388.26	
15341		APPLY CULT SKIN SUB, ADDED	75.02	71.44	421.80	388.26	
15365		APPLY CULT DERM SUB F/N/HF/G	542.33	517.83	421.80	388.26	
15366		APPLY CULT DERM F/HF/G ADDED	126.15	121.79	421.80	388.26	
15430		APPLY ACELLULAR XENOGRAFT	861.84	822.78	619.29	570.03	
15431		APPLY ACELLULAR XENOGRAFT ADDED	328.03	316.57	619.29	570.03	
15570		FORM SKIN PEDICLE FLAP	1,424.66	1,361.15	2,972.49	2,736.03	
15572		FORM SKIN PEDICLE FLAP	1,388.47	1,326.28	2,972.49	2,736.03	
15574		FORM SKIN PEDICLE FLAP	1,451.66	1,386.66	2,972.49	2,736.03	
15576		FORM SKIN PEDICLE FLAP	1,291.01	1,232.56	2,972.49	2,736.03	
15620		SKIN GRAFT	709.40	673.04	2,972.49	2,736.03	
15732		MUSCLE-SKIN GRAFT, HEAD/NECK	2,390.54	2,290.95	2,972.49	2,736.03	
15734		MUSCLE-SKIN GRAFT, TRUNK	2,429.96	2,329.20	2,972.49	2,736.03	
15736		MUSCLE-SKIN GRAFT, ARM	2,142.30	2,051.77	2,972.49	2,736.03	
15738		MUSCLE-SKIN GRAFT, LEG	2,272.44	2,179.61	2,972.49	2,736.03	
15756		FREE MYO/SKIN FLAP MICROVASC	3,749.52	3,610.13			
15770		DERMA-FAT-FASCIA GRAFT	1,066.42	1,022.37	2,972.49	2,736.03	
15780		ABRASION TREAT SKIN	1,322.37	1,259.08	1,641.36	1,510.80	
15781		ABRASION TREAT SKIN	879.47	835.31	678.84	624.84	
15782		ABRASION TREAT SKIN	900.92	853.46	678.84	624.84	
15786		ABRASION, LESION, SING	391.74	371.66	121.44	111.78	
15787		ABRASION, LESIONS, ADDED	78.22	73.91	119.34	109.86	
15823		REVISE UPPER EYELID	979.35	934.65	2,972.49	2,736.03	
15830		EXCISE SKIN ABD	979.35	934.65	3,188.13	2,934.54	
15832		EXCISE EXCESSIVE SKIN TISSUE	979.35	934.65	3,188.13	2,934.54	
15851		REMOVE SUTURES	152.95	145.19	207.09	190.59	
15852		DRESSING CHANGE NOT FOR BURN	73.04	70.73	89.55	82.44	X
15940		REMOVE HIP PRESSURE SORE	1,088.76	1,047.78	3,188.13	2,934.54	
15941		REMOVE HIP PRESSURE SORE	1,419.04	1,362.70	3,188.13	2,934.54	
15944		REMOVE HIP PRESSURE SORE	1,410.54	1,354.92	2,972.49	2,736.03	
15945		REMOVE HIP PRESSURE SORE	1,566.36	1,504.31	2,972.49	2,736.03	
15946		REMOVE HIP PRESSURE SORE	2,593.22	2,494.79	2,972.49	2,736.03	
15950		REMOVE THIGH PRESSURE SORE	898.37	863.19	3,188.13	2,934.54	
15951		REMOVE THIGH PRESSURE SORE	1,357.84	1,302.86	3,188.13	2,934.54	
15952		REMOVE THIGH PRESSURE SORE	1,316.96	1,267.76	2,296.11	2,113.44	
15953		REMOVE THIGH PRESSURE SORE	1,445.87	1,391.23	2,296.11	2,113.44	
15956		REMOVE THIGH PRESSURE SORE	1,823.53	1,754.01	2,296.11	2,113.44	
15958		REMOVE THIGH PRESSURE SORE	1,864.20	1,791.74	2,296.11	2,113.44	
16000		INITIAL TREAT BURN(S)	107.89	103.23	113.49	104.46	
16020		DRESS/DEBRIDE P-THICK BURN, S	132.50	125.94	173.16	159.39	
16025		DRESS/DEBRIDE P-THICK BURN, M	234.02	223.91	199.77	183.90	
16030		DRESS/DEBRIDE P-THICK BURN, L	282.60	269.99	199.77	183.90	
17000		DESTROY PREMALIG LESION	130.90	123.98	121.44	111.78	
17003		DESTROY PREMALIG LES, 2-14	11.64	11.07	15.21	14.01	
17004		DESTROY PREMALIG LESIONS 15+	279.11	265.83	343.95	316.59	
17106		DESTROY SKIN LESIONS	550.21	524.12	364.44	335.43	
17107		DESTROY SKIN LESIONS	713.68	679.99	364.44	335.43	
17108		DESTROY SKIN LESIONS	1,013.03	967.87	364.44	335.43	

CPT* HCPCS	MOD	DESCRIPTION	Physicians' Fees North	Physicians' Fees South	ASC Fees North	ASC Fees South	Payment Indicator (See bottom for codes)
17110		DESTROY B9 LESION, 1-14	180.01	169.92	121.44	111.78	
17111		DSTRJ B9 SK TGS/CUTAN VASC 15/>	213.26	201.74	199.77	183.90	
17250		CHEM CAUT GRANLTJ TISS PROUD FLESH SINUS/FSTL	123.93	117.07	190.68	175.53	
17261		DESTROY SKIN LESIONS	232.56	220.55	199.77	183.90	
17262		DESTROY SKIN LESIONS	281.00	266.92	199.77	183.90	
19000		DRAIN BREAST LESION	179.37	169.75	263.25	242.31	
19120		REMOVE BREAST LESION	750.90	719.29	3,413.91	3,142.35	
19125		EXCISE BREAST LESION	832.58	797.97	3,413.91	3,142.35	
19290		PLACE NEEDLE WIRE, BREAST	262.84	248.72			
20100		EXPLORE WOUND, NECK	927.38	897.30			
20101		EXPLORE WOUND, CHEST	648.74	615.47			
20102		EXPLORE WOUND, ABDOMEN	764.14	725.33			
20103		EXPLORE WOUND, EXTREMITY	914.65	869.73	1,735.95	1,597.86	
20520		REMOVE FOREIGN BODY	311.74	296.49	401.28	369.36	
20525		REMOVE FOREIGN BODY	763.77	723.36	3,188.13	2,934.54	
20526		THERAPEUTIC INJECTION, CARP TUNNEL	118.45	113.27	127.50	117.36	
20550		INJECT TENDON SHEATH/LIGAMENT	89.97	86.03	95.94	88.29	
20551		INJECT TENDON ORIGIN/INSERT	91.72	87.67	99.45	91.53	
20552		INJECT TRIGGER POINT, 1/2 MUSCLE	129.69	123.83	94.77	87.21	
20553		INJECT TRIGGER POINTS, => 3	256.49	244.86	107.64	99.06	
20600		DRAIN/INJ, JOINT/BURSA	85.46	81.58	97.11	89.37	
20605		DRAIN/INJ, JOINT/BURSA	93.41	89.07	109.98	101.22	
20610		DRAIN/INJ, JOINT/BURSA	168.19	160.06	157.95	145.38	
20612		ASPIRATE/INJECT GANGLION CYST	92.67	88.43	106.47	98.01	
20615		TREAT BONE CYST	347.60	330.96	430.50	396.27	
20650		INSERT & REMOVE BONE PIN	313.04	298.60	3,064.83	2,821.05	
20662		APPLY PELVIS BRACE	680.98	652.96	3,064.83	2,821.05	
20663		APPLY THIGH BRACE	724.98	694.28	3,064.83	2,821.05	
20665		REMOVE FIXATION DEVICE			89.55	82.44	X
20670		REMOVE SUPPORT IMPLANT			2,411.70	2,219.85	
20680		REMOVE SUPPORT IMPLANT	976.54	929.22	3,188.13	2,934.54	
20690		APPLY BONE FIXATION DEVICE	2,428.13	2,338.02	4,301.40	3,959.25	
20692		APPLY BONE FIXATION DEVICE	4,571.37	4,397.67	4,301.40	3,959.25	
20693		ADJUST BONE FIXATION DEVICE	1,941.73	1,861.31	3,064.83	2,821.05	
20694		REMOVE BONE FIXATION DEVICE	1,824.61	1,737.34	3,064.83	2,821.05	
20696		COMP MULTIPLANE EXT FIXATION	4,555.72	4,376.97	4,301.40	3,959.25	
20697		COMP EXT FIXATE STRUT CHANGE	7,725.55	7,206.79	2,779.53	2,558.43	
20900		REMOVE BONE FOR GRAFT	673.98	637.99	4,301.40	3,959.25	
20902		REMOVE BONE FOR GRAFT	519.31	498.66	4,301.40	3,959.25	
20910		REMOVE CARTILAGE FOR GRAFT	1,037.67	992.57	2,972.49	2,736.03	
20912		REMOVE CARTILAGE FOR GRAFT	1,198.06	1,147.49	2,972.49	2,736.03	
20920		REMOVE FASCIA FOR GRAFT	985.25	943.49	2,296.11	2,113.44	
20922		REMOVE FASCIA FOR GRAFT	1,471.19	1,405.30	2,296.11	2,113.44	
20924		REMOVE TENDON FOR GRAFT	800.25	767.01	4,301.40	3,959.25	
20926		REMOVE TISSUE FOR GRAFT	692.39	664.11	619.29	570.03	
20931		SP BONE ALLOGRAFT STRUCT, ADDED	480.89	465.78			
20950		FLUID PRESSURE, MUSCLE	1,090.10	1,027.35	198.84	183.03	
20955		FIBULA BONE GRAFT, MICROVASC	10,896.00	10,491.67			
20974		ELECTRICAL BONE STIMULATION	388.51	369.13			
20975		ELECTRICAL BONE STIMULATION	968.04	932.18			

CPT* HCPS	MOD	DESCRIPTION	Physicians' Fees North	Physicians' Fees South	ASC Fees North	ASC Fees South	Payment Indicator (See bottom for codes)
20979		US BONE STIMULATION	288.61	275.42	89.55	82.44	X
20985		COMPUTER-ASSIST DIR MS PX	233.28	225.44			
21060		REMOVE JAW JOINT CARTILAGE	1,303.59	1,251.23	5,961.75	5,487.51	
21070		REMOVE CORONOID PROCESS	2,683.05	2,569.88	5,961.75	5,487.51	
21073		MANIPULATE TMJ W/ANESTH	625.03	593.86	832.95	766.71	
21085		PREPARE FACE/ORAL PROSTHESIS	1,453.19	1,375.54	1,265.82	1,165.11	
21110		INTERDENTAL FIXATION	1,453.19	1,375.54	1,056.45	972.42	
21116		INJECTION, JAW JOINT X-RAY	242.27	228.15			
21209		REDUCE FACIAL BONES	1,356.76	1,290.12	5,961.75	5,487.51	
21210		FACE BONE GRAFT	3,584.38	3,377.47	5,961.75	5,487.51	
21240		RECONSTRUCT JAW JOINT	3,361.24	3,224.68	5,961.75	5,487.51	
21242		RECONSTRUCT JAW JOINT	3,085.47	2,959.40	5,961.75	5,487.51	
21243		RECONSTRUCT JAW JOINT	5,070.37	4,866.28	5,961.75	5,487.51	
21244		RECONSTRUCT LOWER JAW	1,701.06	1,626.83	5,961.75	5,487.51	
21245		RECONSTRUCT JAW	1,819.98	1,735.61	5,961.75	5,487.51	
21246		RECONSTRUCT JAW	1,327.80	1,275.95	5,961.75	5,487.51	
21247		RECONSTRUCT LOWER JAW BONE	2,579.70	2,482.80	5,961.75	5,487.51	
21248		RECONSTRUCT JAW	1,730.48	1,651.07	5,961.75	5,487.51	
21249		RECONSTRUCT JAW	2,370.58	2,265.59	5,961.75	5,487.51	
21310		TREAT NOSE FX	185.45	174.76	151.17	139.14	
21315		TREAT NOSE FX	443.93	419.60	2,313.03	2,129.04	
21320		TREAT NOSE FX	417.47	394.98	2,313.03	2,129.04	
21325		TREAT NOSE FX	772.19	732.88	3,421.41	3,149.25	
21330		TREAT NOSE FX	926.89	881.33	3,421.41	3,149.25	
21335		TREAT NOSE FX	1,181.49	1,128.42	3,421.41	3,149.25	
21356		TREAT CHEEK BONE FX	2,159.27	2,052.68	3,421.41	3,149.25	
21360		TREAT CHEEK BONE FX	2,285.49	2,187.85	3,421.41	3,149.25	
21365		TREAT CHEEK BONE FX	4,774.53	4,590.46			
21366		TREAT CHEEK BONE FX	5,417.56	5,210.50			
21385		TREAT EYE SOCKET FX	3,005.24	2,877.79			
21386		TREAT EYE SOCKET FX	2,849.94	2,739.14			
21390		TREAT EYE SOCKET FX	3,399.51	3,262.80	5,961.75	5,487.51	
21395		TREAT EYE SOCKET FX	4,165.36	3,999.96			
21400		TREAT EYE SOCKET FX	807.13	765.31	1,056.45	972.42	
21401		TREAT EYE SOCKET FX	2,088.19	1,978.92	2,313.03	2,129.04	
21406		TREAT EYE SOCKET FX	2,367.98	2,266.67	5,961.75	5,487.51	
21407		TREAT EYE SOCKET FX	2,782.80	2,670.16	5,961.75	5,487.51	
21408		TREAT EYE SOCKET FX	3,870.37	3,718.17			
21450		TREAT LOWER JAW FX	954.01	901.26	474.09	436.38	
21451		TREAT LOWER JAW FX	1,231.95	1,165.53	1,056.45	972.42	
21452		TREAT LOWER JAW FX	969.53	911.95	2,313.03	2,129.04	
21453		TREAT LOWER JAW FX	1,437.35	1,360.70	5,961.75	5,487.51	
21454		TREAT LOWER JAW FX	889.43	850.92	3,421.41	3,149.25	
21461		TREAT LOWER JAW FX	3,370.55	3,171.80	5,961.75	5,487.51	
21462		TREAT LOWER JAW FX	3,567.33	3,359.58	5,961.75	5,487.51	
21465		TREAT LOWER JAW FX	1,514.36	1,453.74	5,961.75	5,487.51	
21470		TREAT LOWER JAW FX	1,919.57	1,843.61			
21800		TREAT RIB FX	164.26	156.32	210.60	193.83	
21820		TREAT STERNUM FX	217.62	207.24	210.60	193.83	
21825		TREAT STERNUM FX	900.11	864.97			
22305		TREAT SPINE PROCESS FX			210.60	193.83	

CPT* HCPS	MOD	DESCRIPTION	Physicians' Fees North	Physicians' Fees South	ASC Fees North	ASC Fees South	Payment Indicator (See bottom for codes)
22310		TREAT SPINE FX			734.37	675.96	
22315		TREAT SPINE FX	3,738.68	3,578.03	2,779.53	2,558.43	
22505		MANIPULATE SPINE	214.24	206.29	2,074.56	1,909.53	
22520		PERCUT VERTEBROPLASTY THORACIC			4,301.40	3,959.25	
22521		PERCUT VERTEBROPLASTY LUMBAR			4,301.40	3,959.25	
22522		PERCUT VERTEBROPLASTY ADDED			4,301.40	3,959.25	
22554		NECK SPINE FUSION	6,185.12	5,961.42			
22585		ADDED SPINAL FUSION	1,650.20	1,597.95			
22845		INSERT SPINE FIXATION DEVICE	4,518.17	4,376.06			
22851		APPLY SPINE PROSTH DEVICE	2,507.61	2,427.54			
23120		PARTIAL REMOVE COLLAR BONE	3,521.55	3,374.09	4,301.40	3,959.25	
23125		REMOVE COLLAR BONE	4,270.68	4,099.77	4,301.40	3,959.25	
23130		REMOVE SHOULDER BONE, PART	3,681.64	3,527.78	6,312.78	5,810.61	
23331		REMOVE SHOULDER FOREIGN BODY	3,576.37	3,428.03	3,188.13	2,934.54	
23332		REMOVE SHOULDER FOREIGN BODY	5,348.95	5,138.14			
23350		INJECTION FOR SHOULDER X-RAY	245.78	232.06			
23405		TX SHO AREA 1 TDN	989.02	949.25	4,301.40	3,959.25	
23406		TX SHO AREA MLT TDN THRU SM INC	1,228.87	1,180.78	4,301.40	3,959.25	
23410		OPEN REPAIR OF ROTATOR CUFF, RECENT	3,500.51	3,361.17	6,312.78	5,810.61	
23412		OPEN REPAIR OF ROTATOR CUFF, OLD	3,640.20	3,495.88	6,312.78	5,810.61	
23415		CORACOACROMIAL LIGM RLS +-ACROMP	1,096.46	1,051.70	6,312.78	5,810.61	
23420		RECONSTRUCTION ROTATOR CUFF, OLD	4,128.82	3,965.45	6,312.78	5,810.61	
23430		TENODIS LONG TDN BICEPS	1,169.96	1,123.11	6,312.78	5,810.61	
23440		RESCJ/TRNSPLJ LONG TDN BICEPS	1,192.02	1,145.18	6,312.78	5,810.61	
23470		RECONSTRUCT SHOULDER JOINT	5,149.21	4,954.04			
23472		RECONSTRUCT SHOULDER JOINT	6,369.05	6,131.80			
23480		REVISE COLLAR BONE	3,481.15	3,344.49	6,312.78	5,810.61	
23485		REVISE COLLAR BONE	4,080.99	3,923.94	11,871.09	10,926.78	
23500		TREAT CLAVICLE FX	517.10	320.37	210.60	193.83	
23505		TREAT CLAVICLE FX	836.78	519.25	2,779.53	2,558.43	
23515		TREAT CLAVICLE FX	2,182.75	2,094.37	8,925.39	8,215.41	
23520		TREAT CLAVICLE DISLOCATION	543.64	518.10	734.37	675.96	
23525		TREAT CLAVICLE DISLOCATION	889.99	848.39	734.37	675.96	
23530		TREAT CLAVICLE DISLOCATION	1,683.11	1,615.14	6,420.90	5,910.15	
23540		TREAT CLAVICLE DISLOCATION	526.02	501.82	210.60	193.83	
23545		TREAT CLAVICLE DISLOCATION	963.58	919.00	734.37	675.96	
23550		TREAT CLAVICLE DISLOCATION	1,729.78	1,659.14	6,420.90	5,910.15	
23552		TREAT CLAVICLE DISLOCATION	1,992.63	1,911.66	6,420.90	5,910.15	
23570		TREAT SHOULDER BLADE FX	550.00	524.31	210.60	193.83	
23600		TREAT HUMERUS FX	774.56	479.33	210.60	193.83	
23605		TREAT HUMERUS FX	1,118.44	693.94	2,779.53	2,558.43	
23615		TREAT HUMERUS FX	3,210.58	1,336.23	8,925.39	8,215.41	
23616		TREAT HUMERUS FX	4,569.61	1,904.53	8,925.39	8,215.41	
23620		TREAT HUMERUS FX	640.51	609.71	210.60	193.83	
23625		TREAT HUMERUS FX	910.15	868.61	2,779.53	2,558.43	
23630		TREAT HUMERUS FX	2,340.39	2,246.76	8,925.39	8,215.41	
23650		TREAT SHOULDER DISLOCATION	713.19	443.19	210.60	193.83	
23655		TREAT SHOULDER DISLOCATION	941.00	585.27	2,074.56	1,909.53	
23700		FIXATE SHOULDER	470.07	338.09	2,074.56	1,909.53	
24220		INJECTION FOR ELBOW X-RAY	265.46	251.25			
24300		MANIPULATE ELBOW W/ANESTH	640.74	610.08	2,074.56	1,909.53	

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24305		ARM TENDON LENGTHENING	912.18	874.28	4,301.40	3,959.25	
24340		REPAIR BICEPS TENDON	2,601.25	2,494.51	6,312.78	5,810.61	
24341		REPAIR ARM TENDON/MUSCLE	3,143.66	3,012.32	6,312.78	5,810.61	
24342		REPAIR RUPTURED TENDON	3,306.76	3,175.53	6,312.78	5,810.61	
24343		REPAIR ELBOW LAT LIGAMENT W/TISS	2,987.14	2,862.45	4,301.40	3,959.25	
24500		TREAT HUMERUS FX	549.29	522.97	210.60	193.83	
24505		TREAT HUMERUS FX	780.56	744.97	210.60	193.83	
24515		TREAT HUMERUS FX	1,381.32	1,326.32	8,925.39	8,215.41	
24516		TREAT HUMERUS FX	1,358.43	1,305.28	8,925.39	8,215.41	
24530		TREAT HUMERUS FX	588.23	560.15	210.60	193.83	
24535		TREAT HUMERUS FX	965.43	922.74	734.37	675.96	
24545		TREAT HUMERUS FX	1,456.68	1,399.91	8,925.39	8,215.41	
24546		TREAT HUMERUS FX	1,648.10	1,583.95	8,925.39	8,215.41	
24560		TREAT HUMERUS FX	494.20	470.24	210.60	193.83	
24565		TREAT HUMERUS FX	817.85	781.01	210.60	193.83	
24575		TREAT HUMERUS FX	1,155.33	1,108.02	8,925.39	8,215.41	
24576		TREAT HUMERUS FX	524.86	499.14	210.60	193.83	
24577		TREAT HUMERUS FX	846.15	808.13	210.60	193.83	
24579		TREAT HUMERUS FX	1,314.50	1,261.84	8,925.39	8,215.41	
25000		INCISE TENDON SHEATH	547.09	521.24	3,064.83	2,821.05	
25001		INCISE FLEXOR CARPI RADIALIS	536.36	511.94	3,064.83	2,821.05	
25020		DECOMPRESS FOREARM 1 SPACE	1,767.91	1,684.75	4,301.40	3,959.25	
25023		DECOMPRESS FOREARM 1 SPACE	3,363.81	3,221.26	4,301.40	3,959.25	
25024		DECOMPRESS FOREARM 2 SPACES	2,353.42	2,260.29	4,301.40	3,959.25	
25025		DECOMPRESS FOREARM 2 SPACES	3,669.10	3,530.71	4,301.40	3,959.25	
25118		EXCISE WRIST TENDON SHEATH	607.03	580.07	4,301.40	3,959.25	
25215		REMOVE WRIST BONES	1,898.51	1,818.66	4,301.40	3,959.25	
25246		INJECTION FOR WRIST X-RAY	268.94	254.91			
25259		MANIPULATE WRIST W/ANESTH	644.82	613.89	2,779.53	2,558.43	
25260		REPAIR FOREARM TENDON/MUSCLE	2,008.73	1,921.52	4,301.40	3,959.25	
25263		REPAIR FOREARM TENDON/MUSCLE	1,999.71	1,913.76	4,301.40	3,959.25	
25265		REPAIR FOREARM TENDON/MUSCLE	2,368.51	2,270.10	4,301.40	3,959.25	
25270		REPAIR FOREARM TENDON/MUSCLE	1,592.68	1,522.50	4,301.40	3,959.25	
25272		REPAIR FOREARM TENDON/MUSCLE	1,784.09	1,706.99	4,301.40	3,959.25	
25274		REPAIR FOREARM TENDON/MUSCLE	2,130.04	2,040.87	4,301.40	3,959.25	
25295		RELEASE WRIST/FOREARM TENDON	876.95	838.58	3,064.83	2,821.05	
25500		TREAT FX RADIUS	413.29	393.45	210.60	193.83	
25505		TREAT FX RADIUS	781.41	745.83	734.37	675.96	
25515		TREAT FX RADIUS	1,050.48	1,007.25	6,420.90	5,910.15	
25525		TREAT FX RADIUS	1,246.06	1,195.16	6,420.90	5,910.15	
25526		TREAT FX RADIUS	1,533.29	1,471.52	6,420.90	5,910.15	
25530		TREAT FX ULNA	402.85	382.70	210.60	193.83	
25535		TREAT FX ULNA	760.01	725.62	210.60	193.83	
25545		TREAT FX ULNA	981.64	940.37	6,420.90	5,910.15	
25560		TREAT FX RADIUS & ULNA	808.02	769.13	210.60	193.83	
25565		TREAT FX RADIUS & ULNA	1,566.66	1,496.29	734.37	675.96	
25574		TREAT FX RADIUS & ULNA	2,025.40	1,942.13	8,925.39	8,215.41	
25575		TREAT FX RADIUS/ULNA	2,717.76	2,608.67	8,925.39	8,215.41	
25600		TREAT FX RADIUS/ULNA	869.76	827.89	210.60	193.83	
25605		TREAT FX RADIUS/ULNA	1,865.53	1,783.62	734.37	675.96	
25606		TREAT FX DISTAL RADIAL	2,018.97	1,933.22	3,542.43	3,260.64	

CPT* HCPCS	MOD	DESCRIPTION	Physicians' Fees North	Physicians' Fees South	ASC Fees North	ASC Fees South	Payment Indicator (See bottom for codes)
25607		TREAT FX RADIAL EXTRA-ARTICULAR	2,204.51	2,113.59	8,925.39	8,215.41	
25608		TREAT FX RADIAL INTRA-ARTICULAR	2,472.05	2,371.92	8,925.39	8,215.41	
25609		TREAT FX RADIAL 3+ FRAG	3,148.22	3,022.40	8,925.39	8,215.41	
25622		TREAT WRIST BONE FX	900.97	857.05	210.60	193.83	
25624		TREAT WRIST BONE FX	1,384.38	1,319.72	734.37	675.96	
25628		TREAT WRIST BONE FX	2,177.02	2,087.90	6,420.90	5,910.15	
25630		TREAT WRIST BONE FX	909.36	866.26	210.60	193.83	
25635		TREAT WRIST BONE FX	1,342.79	1,280.29	210.60	193.83	
25645		TREAT WRIST BONE FX	1,718.80	1,648.07	6,420.90	5,910.15	
25650		TREAT WRIST BONE FX	953.03	908.21	210.60	193.83	
25652		TREAT FX ULNAR STYLOID	1,879.79	1,801.28	6,420.90	5,910.15	
25670		TREAT FX ULNAR STYLOID	1,831.97	1,757.00	3,542.43	3,260.64	
25671		TREAT FX ULNAR STYLOID	1,598.39	1,529.90	3,542.43	3,260.64	
25676		TREAT WRIST DISLOCATION	1,911.46	1,832.38	3,542.43	3,260.64	
25680		TREAT WRIST FX	1,383.37	1,326.99	210.60	193.83	
25685		TREAT WRIST FX	2,218.61	2,130.23	3,542.43	3,260.64	
26055		INCISE FINGER TENDON SHEATH	910.15	858.58	2,289.75	2,107.62	
26116		EXCISE HAND TUMOR DEEP < 1.5 CM	1,590.71	1,523.59	2,411.70	2,219.85	
26140		REVISE FINGER JOINT, EACH	1,527.77	1,462.59	2,289.75	2,107.62	
26145		TENDON EXCISE PALM/FINGER	2,479.64	2,374.52	2,289.75	2,107.62	
26340		MANIPULATE FINGER W/ANESTH	521.42	495.05	734.37	675.96	
26410		REPAIR HAND TENDON	1,739.49	1,650.91	2,289.75	2,107.62	
26418		REPAIR FINGER TENDON	2,125.52	2,014.58	2,289.75	2,107.62	
26445		RELEASE HAND/FINGER TENDON	1,786.60	1,692.75	2,289.75	2,107.62	
26480		TRANSPLANT HAND TENDON	2,307.21	2,192.78	3,971.19	3,655.32	
26525		RELEASE FINGER CONTRACTURE	2,010.20	1,907.42	2,289.75	2,107.62	
26540		REPAIR HAND JOINT	2,010.67	1,914.55	2,289.75	2,107.62	
26600		TREAT METACARPAL FX	447.47	425.44	210.60	193.83	
26605		TREAT METACARPAL FX	499.07	474.91	210.60	193.83	
26607		TREAT METACARPAL FX	702.97	672.84	2,779.53	2,558.43	
26608		TREAT METACARPAL FX	1,155.32	1,104.12	3,542.43	3,260.64	
26615		TREAT METACARPAL FX	1,371.83	1,313.19	6,420.90	5,910.15	
26720		TREAT FINGER FX, EACH	303.29	288.37	210.60	193.83	
26725		TREAT FINGER FX, EACH	526.64	502.01	210.60	193.83	
26727		TREAT FINGER FX, EACH	739.96	706.95	3,542.43	3,260.64	
26735		TREAT FINGER FX, EACH	925.25	886.02	3,542.43	3,260.64	
26740		TREAT FINGER FX, EACH	352.67	335.26	210.60	193.83	
26742		TREAT FINGER FX, EACH	571.25	545.14	210.60	193.83	
26746		TREAT FINGER FX, EACH	1,143.63	1,096.98	3,542.43	3,260.64	
26750		TREAT FINGER FX, EACH	280.86	267.55	210.60	193.83	
26755		TREAT FINGER FX, EACH	484.57	461.98	210.60	193.83	
27036		EXCISE HIP JOINT/MUSCLE	3,050.71	2,932.10			
27093		INJECTION FOR HIP X-RAY	313.73	296.32			
27095		INJECTION FOR HIP X-RAY	384.77	363.23			
27096		INJECT SACROILIAC JOINT	586.47	554.47	1,012.32	931.80	
27130		TOTAL HIP ARTHROPLASTY	5,258.22	5,062.44			
27132		TOTAL HIP ARTHROPLASTY	6,133.86	5,907.48			
27193		TREAT PELVIC RING FX	1,417.56	1,359.02	210.60	193.83	
27194		TREAT PELVIC RING FX	2,095.30	2,013.65	2,074.56	1,909.53	
27227		TREAT HIP FX(S)	5,066.90	4,879.61			
27228		TREAT HIP FX(S)	5,779.51	5,567.94			

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32551		INSERT CHEST TUBE	523.12	506.94			
32601		THORACOSCOPY, DIAGNOSTIC	499.24	483.47			
32651		THORACOSCOPY, SURGICAL	1,750.69	1,694.03			
32653		THORACOSCOPY, SURGICAL	1,686.57	1,632.06			
33210		INSERT HEART ELECTRODE	297.55	288.11	3,763.15	3,209.05	
33212		INSERT PULSE GENERATOR	564.31	544.12	11,119.83	9,530.10	
36000		PLACE NEEDLE IN VEIN	41.55	39.31			
36005		INJECTION EXT VENOGRAPHY	590.62	553.75			
36010		PLACE CATHETER IN VEIN	952.65	895.82			
36011		PLACE CATHETER IN VEIN	1,569.24	1,473.07			
36013		PLACE CATHETER IN ARTERY	1,386.90	1,301.48			
36014		PLACE CATHETER IN ARTERY	1,452.05	1,363.05			
36140		ESTABLISH ACCESS TO ARTERY	818.12	769.44			
36200		PLACE CATHETER IN AORTA	1,104.48	1,039.78			
36215		PLACE CATHETER IN ARTERY	1,968.28	1,850.35			
36216		PLACE CATHETER IN ARTERY	2,164.58	2,035.32			
36217		PLACE CATHETER IN ARTERY	3,554.81	3,335.12			
36218		PLACE CATHETER IN ARTERY	325.68	306.84			
36245		PLACE CATHETER IN ARTERY	2,078.60	1,953.45			
36246		PLACE CATHETER IN ARTERY	2,094.97	1,970.56			
36247		PLACE CATHETER IN ARTERY	3,310.67	3,107.79			
36248		PLACE CATHETER IN ARTERY	272.11	256.86			
36400		BLOOD DRAW < 3 YRS FEM/JUGULAR	46.92	44.88			
36406		BLOOD DRAW < 3 YRS OTHER VEIN	28.17	26.82			
36410		NON-ROUTINE BL DRAW > 3 YRS	29.91	28.45			
36425		VEIN ACCESS CUTDOWN > 1 YR	62.34	60.40	35.67	32.82	X
36430		BLOOD TRANSFUSION SERVICE	59.91	55.92	119.34	109.86	X
36471		INJECTION THERAPY VEINS	290.72	276.37	121.44	111.78	
36513		APHERESIS PLATELETS	158.96	153.73	1,652.49	1,521.03	X
36514		APHERESIS PLASMA	878.54	824.72	1,652.49	1,521.03	X
36515		APHERESIS, ADSORP/REINFUSE	3,313.31	3,095.86	4,195.89	3,862.11	X
36555		INSERT NON-TUNNEL CV CATH	442.67	420.24	1,516.71	1,396.08	
36556		INSERT NON-TUNNEL CV CATH	383.48	364.91	1,516.71	1,396.08	
36558		INSERT TUNNELED CV CATH	1,353.89	1,277.30	2,289.41	2,017.01	
36569		INSERT PICC CATH	430.72	406.86	1,516.71	1,396.08	
36571		INSERT PICVAD CATH	2,151.26	2,023.38	2,289.41	2,017.01	
36576		REPAIR TUNNELED CV CATH	619.78	588.02	1,516.71	1,396.08	
36578		REPLACE TUNNELED CV CATH	855.29	808.35	2,289.41	2,017.01	
36580		REPLACE CVAD CATH	375.27	353.82	1,516.71	1,396.08	
36584		REPLACE PICC CATH	360.67	339.77	1,516.71	1,396.08	
36589		REMOVE TUNNELED CV CATH	271.78	260.38	844.41	777.24	
36592		COLLECT BLOOD PICC	44.20	41.25			
36593		DELOT VASCULAR DEVICE	49.44	46.14	98.28	90.45	
36598		INJECT W/FLUOR, EVAL CV DEVICE	189.67	178.99	298.32	274.59	
36600		WITHDRAW ARTERIAL BLOOD	50.41	47.90			
36620		INSERT CATHETER, ARTERY	210.31	204.69			
36625		INSERT CATHETER, ARTERY	169.68	164.90			
36800		INSERT CANNULA	261.61	251.45	4,009.88	3,637.55	
36810		INSERT CANNULA	340.24	329.61	4,009.88	3,637.55	
36815		INSERT CANNULA	244.77	236.68	4,009.88	3,637.55	
36818		AV FUSE, UPPER ARM, CEPHALIC	1,105.69	1,069.72	5,565.66	5,122.95	

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36833		AV FISTULA REVISION	1,079.72	1,045.86	5,565.66	5,122.95	
36860		EXTERNAL CANNULA DECLOTTING	331.55	315.10	313.14	288.21	
37140		REVISE CIRCULATION	2,310.08	2,235.33			
37204		TRANSCATHETER OCCLUSION	1,460.69	1,414.57	8,466.97	7,482.97	
37609		TEMPORAL ARTERY PROCEDURE	503.08	478.98	2,411.70	2,219.85	
37620		REVISE MAJOR VEIN	2,029.20	1,958.69			
37650		REVISE MAJOR VEIN	1,545.07	1,493.80	3,662.31	3,370.98	
38100		REMOVE SPLEEN, TOTAL	1,765.00	1,708.45			
38115		REPAIR RUPTURED SPLEEN	1,947.72	1,885.34			
38200		INJECTION FOR SPLEEN X-RAY	234.86	227.73			
38206		HARVEST AUTO STEM CELLS	292.33	282.03	1,652.49	1,521.03	X
38220		BONE MARROW ASPIRATION	250.35	236.57	381.36	351.03	
38221		BONE MARROW BIOPSY	269.34	254.87	393.09	361.80	
38230		BONE MARROW COLLECTION	838.42	806.23	4,195.89	3,862.11	X
39501		REPAIR DIAPHRAGM LACERATION	1,328.67	1,283.88			
43235		UPPER GI ENDOSCOPY, DIAGNOSIS	490.49	464.67	1,184.82	1,090.56	
43236		UPPER GI SCOPE W/SUBMUCOSA INJECT	608.49	576.22	1,184.82	1,090.56	
43239		UPPER GI ENDOSCOPY, BIOPSY	567.52	537.88	1,184.82	1,090.56	
43246		PLACE GASTROSTOMY TUBE	403.59	389.45	1,184.82	1,090.56	
43248		UPPER GI ENDOSCOPY/GUIDE WIRE	303.20	292.10	1,184.82	1,090.56	
43249		ESOPH ENDOSCOPY, DILATION	279.64	269.41	1,184.82	1,090.56	
43255		OPERATIVE UPPER GI ENDOSCOPY	453.95	437.69	1,184.82	1,090.56	
43259		ENDOSCOPIC ULTRASOUND EXAM	488.13	470.63	1,184.82	1,090.56	
43260		ENDO CHOLANGIOPANCREATOGRAPHY	556.81	536.98	3,099.69	2,853.12	
43450		DILATE ESOPHAGUS	258.48	245.26	875.61	805.98	
43760		CHANGE GASTROSTOMY TUBE	684.75	641.43	313.14	288.21	
43830		PLACE GASTROSTOMY TUBE	1,076.48	1,038.48			
44139		MOBILIZATION COLON	187.28	181.69			
44500		INTRODUCE GASTROINTESTINAL TUBE	38.60	37.33	844.41	777.24	
45300		PROCTOSIGMOIDOSCOPY DIAG	187.75	177.52	283.11	260.58	
45330		DIAGNOSTIC SIGMOIDOSCOPY	227.77	215.31	345.12	317.67	
45355		SURGICAL COLONOSCOPY	324.09	312.96	1,246.23	1,147.08	
45378		DIAGNOSTIC COLONOSCOPY	647.09	614.70	1,246.23	1,147.08	
46040		INCISE RECTAL ABSCESS	811.58	773.85	3,247.68	2,989.32	
46600		DIAGNOSTIC ANOSCOPY	136.30	128.76	89.55	82.44	X
47000		NEEDLE BIOPSY LIVER	575.57	542.24	1,298.73	1,195.41	
49080		PUNCTURE, PERITONEAL CAVITY	269.24	254.87	742.11	683.10	
49320		DIAG LAP SEPARATE PROC	508.88	490.86	5,156.19	4,746.03	
49421		INSERT ABDOM DRAIN, PERM	425.09	409.71	3,521.06	3,192.08	
49505		PART RPR I/HERNIA INIT REDUCT >5 YR	799.46	771.01	4,412.82	4,061.82	
50392		INSERT KIDNEY DRAIN	289.62	279.48	2,344.41	2,157.93	
50394		INJECTION FOR KIDNEY X-RAY	173.81	164.23			
51600		INJECTION FOR BLADDER X-RAY	328.90	309.24			
51610		INJECTION FOR BLADDER X-RAY	184.26	174.79			
51700		IRRIGATION BLADDER	143.15	135.97	189.51	174.45	
51701		INSERT BLADDER CATHETER	98.42	93.21	89.55	82.44	X
51702		INSERT TEMP BLADDER CATH	128.12	120.92	89.55	82.44	X
51703		INSERT BLADDER CATH, COMPLEX	227.44	216.26	148.20	136.41	
51705		CHANGE BLADDER TUBE	186.01	176.43	256.20	235.83	
51720		TREAT BLADDER LESION	185.88	177.55	205.92	189.54	
51725		SIMPLE CYSTOMETROGRAM	349.50	330.16			

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51725	TC	SIMPLE CYSTOMETROGRAM	228.20	212.91	428.43	394.35	
51725	26	SIMPLE CYSTOMETROGRAM	121.30	117.25			
51726		COMPLEX CYSTOMETROGRAM	514.29	484.52			
51726	TC	COMPLEX CYSTOMETROGRAM	375.98	350.82	428.43	394.35	
51726	26	COMPLEX CYSTOMETROGRAM	138.31	133.68			
51741		ELECTRO-UROFLOWMETRY, FIRST	72.56	68.17			
51741	TC	ELECTRO-UROFLOWMETRY, FIRST	45.36	42.35	90.09	82.92	
51741	26	ELECTRO-UROFLOWMETRY, FIRST	27.20	25.82			
51784		ANAL/URINARY MUSCLE STUDY	340.60	321.93			
51784	TC	ANAL/URINARY MUSCLE STUDY	217.71	203.13	148.20	136.41	
51784	26	ANAL/URINARY MUSCLE STUDY	122.90	118.80			
51797		INTRAABDOMINAL PRESSURE TEST	225.40	212.42			
51797	TC	INTRAABDOMINAL PRESSURE TEST	159.49	148.82	271.74	250.14	
51797	26	INTRAABDOMINAL PRESSURE TEST	65.91	63.61			
51798		US URINE CAPACITY MEASURE	33.71	31.48	66.69	61.38	X
52000		CYSTOSCOPY	348.14	331.01	992.58	913.62	
52005		CYSTOSCOPY & URETER CATHETER	482.13	456.37	3,512.94	3,233.49	
52204		CYSTOSCOPY W/BIOPSY(S)	706.29	666.08	3,512.94	3,233.49	
52281		CYSTOSCOPY & TREAT	481.96	456.89	2,344.41	2,157.93	
52310		CYSTOSCOPY & TREAT	412.14	392.33	2,344.41	2,157.93	
52332		CYSTOSCOPY & TREAT	837.81	788.80	3,512.94	3,233.49	
52351		CYSTOURETERO & OR PYELOSCOPE	511.15	493.07	3,512.94	3,233.49	
53600		DILATE URETHRA STRICTURE	139.91	133.85	146.22	134.61	
53601		DILATE URETHRA STRICTURE	137.75	131.17	148.20	136.41	
53660		DILATE URETHRA	121.77	115.58	148.20	136.41	
53661		DILATE URETHRA	120.54	114.44	148.20	136.41	
54235		PENILE INJECTION	149.95	143.17	168.48	155.07	
57452		EXAM CERVIX W/SCOPE	174.20	167.01	171.99	158.31	
57500		BIOPSY CERVIX	213.96	203.21	286.62	263.82	
57511		CRYOCAUTERY CERVIX	234.32	224.50	218.10	200.76	
58340		CATHETER FOR HYSTERORRHAPHY	203.46	192.36			
58558		HYSTEROSCOPY, BIOPSY	576.77	552.42	3,079.32	2,834.37	
59000		AMNIOCENTESIS, DIAGNOSTIC	208.66	199.11	248.01	228.30	
59025		FETAL NON-STRESS TEST	117.18	112.00			
59025	TC	FETAL NON-STRESS TEST	45.58	42.59	58.50	53.85	
59025	26	FETAL NON-STRESS TEST	71.58	69.41			
59841		ABORTION	611.45	589.83	2,758.50	2,539.05	
61107		DRILL SKULL FOR IMPLANTATION	1,155.41	1,120.28			
61790		TREAT TRIGEMINAL NERVE			2,552.34	2,349.30	
62263		EPIDURAL LYSIS MULT SESSIONS	1,788.44	1,102.21	1,012.32	931.80	
62264		EPIDURAL LYSIS ON SINGLE DAY	1,033.30	638.56	1,706.88	1,571.10	
62270		SPINAL FLUID TAP, DIAGNOSTIC	391.43	371.51	517.89	476.70	
62273		INJECT EPIDURAL PATCH	414.98	396.26	1,012.32	931.80	
62280		TREAT SPINAL CORD LESION	817.78	775.41	1,012.32	931.80	
62281		TREAT SPINAL CORD LESION	650.31	618.08	1,012.32	931.80	
62282		TREAT SPINAL CANAL LESION	743.51	703.87	1,012.32	931.80	
62284		INJECTION FOR MYELOGRAM	544.03	514.23			
62287		PERCUTANEOUS DISKECTOMY	5,347.03	5,141.26	4,972.53	4,576.98	
62290		INJECT FOR SPINE DISK X-RAY	1,256.74	1,191.64			
62291		INJECT FOR SPINE DISK X-RAY	1,184.82	1,123.82			
62292		INJECTION INTO DISK LESION	1,982.34	1,907.34	1,012.32	931.80	

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62310		INJECT SPINE C/T	1,021.73	967.17	1,012.32	931.80	
62311		INJECT SPINE L/S (CD)	879.37	831.58	1,012.32	931.80	
62318		INJECT SPINE W/CATH, C/T	749.21	709.56	1,012.32	931.80	
62319		INJECT SPINE W/CATH L/S (CD)	475.01	451.01	1,706.88	1,571.10	
62350		IMPLANT SPINAL CANAL CATH			5,591.79	5,146.98	
62355		REMOVE SPINAL CANAL CATHETER			1,706.88	1,571.10	
62360		INSERT SPINE INFUSION DEVICE			5,591.79	5,146.98	
62362		IMPLANT SPINE INFUSION PUMP			22,241.41	18,893.98	
62365		REMOVE SPINE INFUSION DEVICE			4,972.53	4,576.98	
62367		ANALYZE SPINE INFUSION PUMP			76.02	69.99	X
62368		ANALYZE SPINE INFUSION PUMP			102.96	94.77	X
63075		NECK SPINE DISK SURG	10,012.99	9,659.93			
63076		NECK SPINE DISK SURG	1,837.46	1,779.74			
63650		IMPLANT NEUROELECTRODES			7,941.86	6,926.39	X
63655		IMPLANT NEUROELECTRODES			10,702.41	9,271.65	X
63685		INSERT/REDO SPINE N GENERATOR			24,642.86	20,858.66	X
63688		REVISE/REMOVE NEURORECEIVER			3,880.14	3,571.47	
64400		NERVE BLOCK INJ, TRIGEMINAL			237.48	218.58	
64402		NERVE BLOCK INJ, FACIAL	280.41	267.23	219.96	202.47	
64405		NERVE BLOCK INJ, OCCIPITAL	278.84	266.46	202.38	186.30	
64412		NERVE BLOCK INJ, SPINAL ACCESSORY			352.14	324.12	
64413		NERVE BLOCK INJ, CERV PLEXUS	294.62	281.16	221.13	203.55	
64415		NERVE BLOCK INJ, BRACHIAL PLEXUS	304.42	290.12	517.89	476.70	
64416		NERVE BLOCK CONT INFUSE, B PLEX	191.93	186.58	1,012.32	931.80	
64417		NERVE BLOCK INJ, AXILLARY	320.99	305.45	517.89	476.70	
64418		NERVE BLOCK INJ, SUPRASCAPULAR	344.67	327.13	303.00	278.91	
64420		NERVE BLOCK INJ, INTERCOSTAL, SING	343.60	325.60	517.89	476.70	
64421		NERVE BLOCK INJ, INTERCOSTAL, MULT	493.86	468.06	1,012.32	931.80	
64425		NERVE BLOCK INJ, ILIO-ING/HYPOGI	321.93	307.96	221.13	203.55	
64430		NERVE BLOCK INJ, PUDENDAL			1,012.32	931.80	
64435		NERVE BLOCK INJ, PARACERV	352.78	335.81	287.79	264.90	
64445		NERVE BLOCK INJ, SCIATIC, SING	333.50	317.51	267.93	246.60	
64446		NERVE BLOCK INJ, SCIATIC, CONT INF			1,012.32	931.80	
64447		NERVE BLOCK INJ, FEM, SING	295.21	281.61	221.13	203.55	
64448		NERVE BLOCK INJ, FEM, CONT INF			1,012.32	931.80	
64449		NERVE BLOCK INJ, LUMBAR PLEXUS	199.08	193.27	1,012.32	931.80	
64450		NERVE BLOCK, OTHER PERIPHERAL	253.98	242.28	190.68	175.53	
64455		NERVE BLOCK INJ, PLANTAR DIGIT			71.37	65.70	
64479		INJECT FORAMEN EPIDURAL C/T	670.71	635.70	1,012.32	931.80	
64480		INJECT FORAMEN EPIDURAL, ADDED	397.14	377.32	517.89	476.70	
64483		INJECT FORAMEN EPIDURAL L/S	611.76	578.07	1,012.32	931.80	
64484		INJECT FORAMEN EPIDURAL, ADDED	268.13	254.31	517.89	476.70	
64490		INJECT PARAVERT F JNT C/T 1 LEV	494.93	469.59	1,012.32	931.80	
64491		INJECT PARAVERT F JNT C/T 2 LEV	241.80	230.50	355.95	327.66	
64492		INJECT PARAVERT F JNT C/T 3 LEV	244.49	233.01	355.95	327.66	
64493		INJECT PARAVERT F JNT L/S 1 LEV	442.52	419.26	1,012.32	931.80	
64494		INJECT PARAVERT F JNT L/S 2 LEV	218.85	208.33	355.95	327.66	
64495		INJECT PARAVERT F JNT L/S 3 LEV	222.43	211.68	355.95	327.66	
64505		NERVE BLOCK SPHENOPALATINE GANGLIA	241.39	230.83	166.14	152.91	
64510		NERVE BLOCK STELLATE GANGLION	340.64	322.89	1,012.32	931.80	
64517		NERVE BLOCK INJ, HYPOGAS PLXS	429.82	410.19	1,012.32	931.80	

CPT* HCPS	MOD	DESCRIPTION	Physicians' Fees North	Physicians' Fees South	ASC Fees North	ASC Fees South	Payment Indicator (See bottom for codes)
64520		NERVE BLOCK LUMBAR/THORACIC	486.86	459.82	1,012.32	931.80	
64550		APPLY NEUROSTIMULATOR	25.38	24.14			
64555		IMPLANT NEUROELECTRODES			7,941.86	6,926.39	X
64561		IMPLANT NEUROELECTRODES			7,941.86	6,926.39	X
64565		IMPLANT NEUROELECTRODES	286.59	272.61	7,941.86	6,926.39	X
64600		INJECTION TREAT NERVE	673.41	638.56	1,706.88	1,571.10	
64605		INJECTION TREAT NERVE	1,063.67	1,007.56	2,552.34	2,349.30	
64610		INJECTION TREAT NERVE	1,180.01	1,125.84	2,552.34	2,349.30	
64612		DESTROY NERVE, FACE MUSCLE	316.60	303.63	278.43	256.26	
64613		DESTROY NERVE, NECK MUSCLE	302.92	290.62	260.91	240.15	
64614		DESTROY NERVE, EXTREMITY MUSC	324.01	310.13	295.98	272.43	
64620		INJECTION TREAT NERVE	385.92	368.07	1,012.32	931.80	
64622		DESTROY PARAVERTEBRAL NERVE L/S	634.27	601.31	1,706.88	1,571.10	
64623		DESTROY PARAVERT NERVE, ADDED	317.51	300.33	1,012.32	931.80	
64626		DESTROY PARAVERTEBRAL NERVE C/T	751.82	713.75	1,012.32	931.80	
64627		DESTROY PARAVERT NERVE, ADDED	436.29	411.90	355.95	327.66	
64640		INJECTION TREAT NERVE	404.68	386.40	393.09	361.80	
64680		INJECTION TREAT NERVE	594.94	563.72	1,012.32	931.80	
64702		REVISE FINGER/TOE NERVE			2,552.34	2,349.30	
64704		REVISE HAND/FOOT NERVE			2,552.34	2,349.30	
64708		REVISE ARM/LEG NERVE			2,552.34	2,349.30	
64712		REVISE SCIATIC NERVE			2,552.34	2,349.30	
64713		REVISE ARM NERVE(S)			2,552.34	2,349.30	
64714		REVISE LOW BACK NERVE(S)			2,552.34	2,349.30	
64716		REVISE CRANIAL NERVE			2,552.34	2,349.30	
64718		REVISE ULNAR NERVE AT ELBOW			2,552.34	2,349.30	
64719		REVISE ULNAR NERVE AT WRIST			2,552.34	2,349.30	
64721		CARPAL TUNNEL SURG	2,074.12	1,982.69	2,552.34	2,349.30	
64818		REMOVE SYMPATHETIC NERVES	1,606.35	1,552.19			
65205		REMOVE FOREIGN BODY EYE	132.40	126.72	90.09	82.92	X
65210		REMOVE FOREIGN BODY EYE	164.76	157.50	117.00	107.70	X
65220		REMOVE FOREIGN BODY EYE	136.80	130.87	129.36	119.07	X
65222		REMOVE FOREIGN BODY EYE	181.46	173.50	127.50	117.36	X
65265		REMOVE FOREIGN BODY EYE	2,640.72	2,533.79	3,125.70	2,877.06	
67412		EXPLORE/TREAT EYE SOCKET	2,070.04	1,979.70	2,669.28	2,456.94	
69210		REMOVE IMPACTED EAR WAX	80.59	76.92	89.55	82.44	X
69310		REBUILD OUTER EAR CANAL	1,786.26	1,698.11	5,961.75	5,487.51	
69320		REBUILD OUTER EAR CANAL	2,511.83	2,392.78	5,961.75	5,487.51	
69666		REPAIR MIDDLE EAR STRUCTURES	3,035.82	2,897.99	5,961.75	5,487.51	
69667		REPAIR MIDDLE EAR STRUCTURES	3,041.01	2,902.91	5,961.75	5,487.51	
69990		MICROSURG, ADDED	529.56	513.23			
70030		X-RAY EYE FOR FOREIGN BODY	48.10	45.35			
70030	TC	X-RAY EYE FOR FOREIGN BODY	34.87	32.57	69.03	63.54	
70030	26	X-RAY EYE FOR FOREIGN BODY	13.22	12.79			
70100		X-RAY JAW < 4 VIEWS	55.59	52.37			
70100	TC	X-RAY JAW < 4 VIEWS	41.28	38.54	81.87	75.36	
70100	26	X-RAY JAW < 4 VIEWS	14.31	13.83			
70110		X-RAY JAW MINIMUM 4 VIEWS	66.14	62.37			
70110	TC	X-RAY JAW MINIMUM 4 VIEWS	47.11	43.97	87.24	80.31	
70110	26	X-RAY JAW MINIMUM 4 VIEWS	19.03	18.40			
70120		X-RAY MASTOIDS < 3 VIEWS/SIDE	59.09	55.62			

CPT* HCPS	MOD	DESCRIPTION	Physicians' Fees North	Physicians' Fees South	ASC Fees North	ASC Fees South	Payment Indicator (See bottom for codes)
70120	TC	X-RAY MASTOIDS < 3 VIEWS/SIDE	44.78	41.81	87.24	80.31	
70120	26	X-RAY MASTOIDS < 3 VIEWS/SIDE	14.31	13.83			
70130		X-RAY MASTOIDS MINIMUM 3 VIEWS/SIDE	93.99	88.58			
70130	TC	X-RAY MASTOIDS MINIMUM 3 VIEWS/SIDE	68.07	63.54	87.24	80.31	
70130	26	X-RAY MASTOIDS MINIMUM 3 VIEWS/SIDE	25.92	25.05			
70140		X-RAY FACIAL BONES < 3 VIEWS	50.86	47.98			
70140	TC	X-RAY FACIAL BONES < 3 VIEWS	35.46	33.11	70.20	64.62	
70140	26	X-RAY FACIAL BONES < 3 VIEWS	15.40	14.86			
70150		X-RAY FACIAL BONES MINIMUM 3 VIEWS	71.88	67.76			
70150	TC	X-RAY FACIAL BONES MINIMUM 3 VIEWS	51.76	48.32	87.24	80.31	
70150	26	X-RAY FACIAL BONES MINIMUM 3 VIEWS	20.12	19.44			
70160		X-RAY NASAL BONES MINIMUM 3 VIEWS	55.66	52.41			
70160	TC	X-RAY NASAL BONES MINIMUM 3 VIEWS	42.45	39.63	84.21	77.52	
70160	26	X-RAY NASAL BONES MINIMUM 3 VIEWS	13.22	12.79			
70190		X-RAY OPTIC FORAMINA	60.03	56.57			
70190	TC	X-RAY OPTIC FORAMINA	43.61	40.71	86.55	79.68	
70190	26	X-RAY OPTIC FORAMINA	16.41	15.86			
70200		X-RAY ORBITS, MINIMUM 4 VIEWS	74.07	69.85			
70200	TC	X-RAY ORBITS, MINIMUM 4 VIEWS	52.34	48.86	87.24	80.31	
70200	26	X-RAY ORBITS, MINIMUM 4 VIEWS	21.71	20.98			
70210		X-RAY SINUSES < 3 VIEWS	52.17	49.16			
70210	TC	X-RAY SINUSES < 3 VIEWS	38.37	35.83	76.02	69.99	
70210	26	X-RAY SINUSES < 3 VIEWS	13.80	13.33			
70220		X-RAY SINUSES MINIMUM 3 VIEWS	64.97	61.29			
70220	TC	X-RAY SINUSES MINIMUM 3 VIEWS	45.94	42.89	87.24	80.31	
70220	26	X-RAY SINUSES MINIMUM 3 VIEWS	19.03	18.40			
70250		X-RAY SKULL < 4 VIEWS	62.13	58.62			
70250	TC	X-RAY SKULL < 4 VIEWS	43.03	40.17	85.38	78.60	
70250	26	X-RAY SKULL < 4 VIEWS	19.10	18.45			
70260		X-RAY SKULL MINIMUM 4 VIEWS	78.86	74.45			
70260	TC	X-RAY SKULL MINIMUM 4 VIEWS	52.92	49.41	105.30	96.93	
70260	26	X-RAY SKULL MINIMUM 4 VIEWS	25.92	25.05			
70300		X-RAY TEETH SINGLE VIEW	24.17	22.85			
70300	TC	X-RAY TEETH SINGLE VIEW	15.08	14.10	29.22	26.91	
70300	26	X-RAY TEETH SINGLE VIEW	9.09	8.75			
70310		X-RAY TEETH < FULL MOUTH	63.31	59.51			
70310	TC	X-RAY TEETH < FULL MOUTH	49.44	46.14	59.04	54.36	
70310	26	X-RAY TEETH < FULL MOUTH	13.88	13.37			
70320		X-RAY TEETH FULL MOUTH	83.72	79.89			
70320	TC	X-RAY TEETH FULL MOUTH	66.90	62.44	59.04	54.36	
70320	26	X-RAY TEETH FULL MOUTH	18.09	17.45			
70328		X-RAY TMJ UNILATERAL	52.10	49.11			
70328	TC	X-RAY TMJ UNILATERAL	37.79	35.29	74.85	68.91	
70328	26	X-RAY TMJ UNILATERAL	14.31	13.83			
70330		X-RAY TMJ BILATERAL	81.34	76.54			
70330	TC	X-RAY TMJ BILATERAL	62.24	58.09	87.24	80.31	
70330	26	X-RAY TMJ BILATERAL	19.10	18.45			
70332		TMJ ARTHOGRAPHY; RAD SUPER & INTERP	143.03	134.89			N1
70332	TC	TMJ ARTHOGRAPHY; RAD SUPER & INTERP	98.34	91.77			N1
70332	26	TMJ ARTHOGRAPHY; RAD SUPER & INTERP	44.68	43.10			N1
70336		MRI TMJ	763.99	716.59			

CPT* HCPCS	DESCRIPTION	Hospital Outpatient Surgical Facility Fees North	Hospital Outpatient Surgical Facility Fees South	Not Subject to Multiple Procedure Reductions	Packaged Item; No Separate Payment	Ancillary Services; Separate Payment
78584	LUNG V/Q IMAGE SINGLE BREATH	1,261.32	1,081.07	X		
78585	LUNG V/Q IMAGING	1,261.32	1,081.07	X		
78588	PERFUSION LUNG IMAGE	1,261.32	1,081.07	X		
78594	VENT IMAGE, MULT PROJ, GAS	776.02	665.13	X		
78596	LUNG DIFFERENTIAL FUNCTION	1,261.32	1,081.07	X		
78607	BRAIN IMAGING (3D)	2,350.85	2,014.92	X		
78707	KID FLOW/FUNCT IMAGE W/O DRUG	1,267.39	1,086.28	X		
78708	KID FLOW/FUNCT IMAGE W/DRUG	1,267.39	1,086.28	X		
78709	KIDNEY IMG MORPHOLOGY VASCULAR FLOW MULTIPLE	1,267.39	1,086.28	X		
78802	TUMOR IMAGING, WHOLE BODY	1,872.66	1,605.05	X		
78803	TUMOR IMAGING (3D)	1,872.66	1,605.05	X		
78805	ABSCESS IMAGING, LTD AREA	1,872.66	1,605.05	X		
78806	ABSCESS IMAGING, WHOLE BODY	1,872.66	1,605.05	X		
78815	PET IMAGE W/CT, SKULL-THIGH	4,108.15	3,521.09	X		
79101	NUCLEAR RX, IV ADMIN	883.62	757.35	X		
88141	CYTOPATH, C/V, INTERPRET				N1	
92070	FIT CONTACT LENS				N1	
92504	EAR MICROSCOPY EXAM				N1	
92547	SUPPLEMENTAL ELECTRICAL TEST				N1	
92621	AUDITORY FUNCTION, + 15 MIN				N1	
93314	ECHO TRANSESOPHAGEAL				N1	
93320	DOPPLER ECHO EXAM, HEART				N1	
93321	DOPPLER ECHO EXAM, HEART				N1	
93325	DOPPLER COLOR FLOW, ADDED				N1	
93463	DRUG ADMIN & HEMODYNMIC MEAS				N1	
93464	EXERCISE W/HEMODYNAMIC MEAS				N1	
93563	INJECT CONGENITAL CARD CATH				N1	
93564	INJECT HEART CONGNL ART/GRAFT				N1	
93565	INJECT L VENTR/ATRIAL ANGIO				N1	
93566	INJECT R VENTR/ATRIAL ANGIO				N1	
93567	INJECT SUPRVLV AORTOGRAPHY				N1	
93568	INJECT PULM ART HEART CATH				N1	
93609	MAP TACHYCARDIA, ADDED				N1	
93623	STIMULATION, PACING HEART				N1	
93641	ELECTROPHYSIOLOGY EVAL				N1	
94760	MEASURE BLOOD OXYGEN LEVEL				N1	
94761	MEASURE BLOOD OXYGEN LEVEL				N1	
95873	GUIDE NERVE DESTROY, ELECT STIM				N1	
95874	GUIDE NERVE DESTROY, NEEDLE EMG				N1	
95920	INTRAOP NERVE TEST, ADDED				N1	
95955	EEG DURING SURG				N1	
95957	EEG DIGITAL ANALYSIS				N1	
96368	THER/DIAG CONCURRENT INF				N1	
99143	MOD SEDATION SAME PHYS, < 5 YRS				N1	
99144	MOD SEDATION BY SAME PHYS, 5 YRS +				N1	
99145	MOD SEDATION BY SAME PHYS, ADDED				N1	
99148	MOD SEDATION DIFF PHYS < 5 YRS				N1	
99149	MOD SEDATION DIFF PHYS 5 YRS +				N1	
99150	MOD SEDATION DIFF PHYS, ADDED				N1	

CPT* HCPCS	DESCRIPTION	Hospital Outpatient Surgical Facility Fees North	Hospital Outpatient Surgical Facility Fees South	Not Subject to Multiple Procedure Reductions	Packaged Item; No Separate Payment	Ancillary Services; Separate Payment
99175	INDUCTION VOMITING				N1	
99292	CRITICAL CARE, ADDED 30 MIN				N1	
99354	PROLONGED SERVICE, OFFICE				N1	
99355	PROLONGED SERVICE, OFFICE				N1	

New Rule, R.2001 d.253, effective July 16, 2001.
 See: 32 N.J.R. 4332(a), 33 N.J.R. 226(a), 33 N.J.R. 2507(a).
 Amended by R.2002 d.59, effective March 4, 2002.
 See: 33 N.J.R. 3617(a), 34 N.J.R. 1032(a).
 Inserted Exhibit 2, Dental Fee Schedule.
 Amended by R.2003 d.143, effective April 7, 2003.
 See: 34 N.J.R. 1237(a), 35 N.J.R. 1547(b).
 Amended Exhibit 3 and inserted Exhibit 6.
 Amended by R.2004 d.481, effective December 20, 2004.
 See: 36 N.J.R. 2579(a), 36 N.J.R. 5912(a).
 Repealed former Exhibit 2 and inserted a new Exhibit 2.
 Petition for Rulemaking: Department of Banking and Insurance; Division of Insurance; Property and Casualty Division; Notice of receipt of petition for rulemaking: review of the medical fee schedule.
 See: 38 N.J.R. 1880(a), 2745(c).
 Petition for Rulemaking: Department of Banking and Insurance; Division of Insurance; Property and Casualty Division; Notice of action on petition for rulemaking: review of the medical fee schedule.
 See: 38 N.J.R. 3681(a).
 Amended by R.2007 d.305, effective October 1, 2007.
 See: 38 N.J.R. 3437(a), 39 N.J.R. 4126(c).
 Former Exhibits 1, 4, 5 and 6 repealed; added new Exhibits 1, 4, 5 and 6; and added Exhibit 7.
 Notice of Stay of Implementation: See: 39 N.J.R. 4849(a).
 By Order of the Appellate Division of the Superior Court of New Jersey entered on September 28, 2007, the implementation of amendments to this rule published in the October 1, 2007 New Jersey Register at 39 N.J.R. 4126(c) was stayed pending a decision in the matter of *Alliance for Quality Care, Inc., et al. v. New Jersey Department of Banking and Insurance*, Docket No. A33-07 T3, now pending before the Appellate Division.
 Amended by R.2009 d.194, effective June 15, 2009.
 See: 40 N.J.R. 6375(a), 41 N.J.R. 2489(a).
 Repealed former Exhibit 3; and added new Exhibit 3.
 Amended by R.2009 d.209, effective July 6, 2009.
 See: 40 N.J.R. 2653(a), 41 N.J.R. 2660(b).
 Repealed former Exhibit 2; and added new Exhibit 2.

Repeal and New Rule, R.2012 d.187, effective November 5, 2012 (operative January 4, 2013).
 See: 43 N.J.R. 1640(a), 44 N.J.R. 383(a), 44 N.J.R. 2652(c).

SUBCHAPTER 30. MOTOR VEHICLE SELF-INSURANCE

11:3-30.1 Purpose

This subchapter sets forth the filing requirements for motor vehicle self-insurers pursuant to N.J.S.A. 39:6-50.1, and 39:6-52 to 39:6-54.

11:3-30.2 Scope

The provisions of this subchapter apply to any person seeking to qualify as a motor vehicle self-insurer in New Jersey, except public entities pursuant to N.J.S.A. 39:6-54.

11:3-30.3 Definitions

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

“Applicant” means a person applying for a certificate of self-insurance who does not currently possess a valid certificate.

“Association” means the New Jersey Automobile Full Insurance Underwriting Association created pursuant to N.J.S.A. 17:30E-1 et seq.

National Highway Traffic and Safety Association
 Docket Room
 NAD-52
 400 Seventh Street, S.W.
 Washington, D.C. 20590

10. A hydraulic brake lock device is qualified if a warning label announces the presence of the device and the device is designed so that:

- i. The device is mounted on the dash;
- ii. When activated and pressurized with the brake pedal, hydraulic pressure is maintained on the brakes at two or more of the automobile's wheels;
- iii. The device has a high security locking system with at least 50,000 combinations; and
- iv. The lock is such that it cannot be pulled using a conventional slide hammer or lock puller equipment.

11. A window etching vehicle identification system is qualified if a warning label announces the presence of the system, and the system is designed so that:

- i. A specific, identifiable set of numbers is permanently etched into all primary window glass areas, either by sandblasting or a chemical process;
- ii. The set of numbers must be traceable to the automobile's registered owner; and
- iii. Immediate telephonic notification or identification of the registrant must be available 24 hours a day, seven days per week.

(d) A device or system qualifies as a Category IV anti-theft or vehicle recovery device if a warning label announces the presence of the device and it meets the following requirements:

- 1. The device or system is designed to transmit a pulse or signal by which the location of the automobile in which the device or system is installed may be tracked by those receiving the signal;
- 2. The device or system is activated or initiated when an automobile is stolen or reported stolen to police;
- 3. The pulse or signal either must be transmittable to the New Jersey State Police or to a private central monitoring station which shall have direct communication with the New Jersey State Police for the purpose of reporting, tracking and monitoring the automobile; and
- 4. The device or system shall be designed so that upon recovery, information concerning the automobile's location may be provided to the proper authorities and/or the automobile's owner or insurer.

(e) All warning labels announcing the presence of an anti-theft or vehicle recovery device or system shall be located so

as to be visible from the automobile's exterior, preferably on the forward passenger and driver's side door windows.

(f) The lists set forth in (a) through (d) above are not exclusive, and shall not prevent an insurer from considering other devices or systems as anti-theft or vehicle recovery devices eligible for reductions in the base rates of comprehensive and theft and fire coverages, in a manner determined by the insurer.

Public Notice: Notice of receipt of and action on Petition for rulemaking for vehicle anti-theft and recovery device.

See: 23 N.J.R. 2786(c).

Notice of Receipt of Petition for Rulemaking: Reductions in Premium Charges for Private Passenger Automobiles Equipped with Anti-Theft, Vehicle Recovery and Safety Devices.

See: 24 N.J.R. 305(a).

Notice of Action on Petition for Rulemaking.

See: 24 N.J.R. 658(a).

Amended by R.1999 d.170, effective June 7, 1999.

See: 30 N.J.R. 2332(a), 31 N.J.R. 1493(a).

Inserted (b)5.

11:3-39.6 Reductions in rates for safety features

(a) Except as (d) below may apply, every insurer writing automobile physical damage insurance shall provide a reduction in the base rates of its collision damage coverage for all private passenger automobiles equipped with one or more safety features. Reductions in the base rates shall be as follows:

- 1. At least five percent for a private passenger automobile equipped with one safety feature;
- 2. An additional 2.5 percent reduction shall be provided for each additional safety feature with which the automobile is equipped; and
- 3. No insurer shall be required to provide more than a 10 percent total reduction for safety features, (a)2 above notwithstanding.

(b) Insurers shall develop a list of features which will qualify as collision damage safety features. This list may include features which are standard features for some private passenger automobiles, but which are options or not available for other private passenger automobiles. This list shall include:

- 1. Anti-lock braking systems;
- 2. Traction control systems; and
- 3. Five-mile-per-hour bumpers.

(c) An insurer may require reasonable proof that a private passenger automobile is equipped with a safety feature before providing any reduction in the base rates for collision damage coverage for private passenger automobiles. An inspection for the issuance or renewal of physical damage coverages, as set forth at N.J.A.C. 11:3-36, shall be considered reasonable proof.

(d) The requirements of (a) through (c) above shall not be applicable to those insurers which utilize make and model rating in pricing collision coverage.

11:3-39.7 Penalties

Any insurer which fails to comply with the terms of this subchapter shall be in violation of this subchapter, and subject to the assessment of any and all penalties in accordance with the laws of this State.

11:3-39.8 Severability

If any provision of this subchapter or application thereof to any person or circumstances is held invalid, the remainder of the subchapter and application of such provisions to other persons or circumstances shall not be affected thereby.

SUBCHAPTERS 40 THROUGH 44. (RESERVED)

SUBCHAPTER 45. INSURERS REQUIRED TO PROVIDE SURVEY INFORMATION

11:3-45.1 Purpose and scope

(a) The purpose of the subchapter is to implement N.J.S.A. 39:6A-23.1 by setting forth those procedures by which insurers shall annually submit to the Department current premium information.

(b) This subchapter shall apply to all auto insurers that have on file with the Department a current personal lines rating system for automobile insurance.

Amended by R.2008 d.380, effective December 15, 2008 (operative January 1, 2009).

See: 40 N.J.R. 3572(a), 40 N.J.R. 6970(b).

In (b), deleted "and which are not exempted from the obligation to insure, renew, or provide automobile insurance to eligible persons. Exempted insurers are listed in N.J.A.C. 11:3-40.3(b), (c) and (d)" at the end.

11:3-45.2 Definitions

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

"Auto insurer" means an entity authorized or admitted to write automobile insurance in New Jersey but does not include any residual market mechanism implemented pursuant to N.J.S.A. 17:29D-1 et seq. or any other statute.

"Automobile insurance" means insurance for private passenger automobile including one or more of the following coverages: bodily injury liability and property damage liability, comprehensive and collision coverages, uninsured and underinsured motorist coverage, personal injury protec-

tion, additional personal injury protection coverage and any other automobile insurance required by law.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"Department" means the New Jersey Department of Banking and Insurance.

"Survey information" means the data annually supplied by the Commissioner to the auto insurers from which they will then issue survey quotations. This information includes, but is not limited to, the prior driving experience of the insured, the nature and extent of coverages, the deductible, the composition of household, information regarding the proposed vehicle, and other pertinent information.

Administrative change.

See: 30 N.J.R. 1317(a).

Amended by R.2008 d.380, effective December 15, 2008 (operative January 1, 2009).

See: 40 N.J.R. 3572(a), 40 N.J.R. 6970(b).

Rewrote definition "Auto insurer".

11:3-45.3 Annual premium survey filing

(a) Every auto insurer shall prepare and file on or before September 15 of each calendar year, with the Department, at the address set forth in (d) below, an annual premium survey reflecting premiums charged for specific automobile insurance coverage.

(b) The filing shall reflect the annual premiums by coverage as of October 1 of that calendar year and shall be predicated on survey information provided by the Commissioner to auto insurers by Bulletin on or before September 1 of each calendar year.

(c) Auto insurers shall prepare and file the information required by this subchapter in accordance with the forms contained in the Appendix and incorporated herein by reference.

(d) Completed annual premium survey forms shall be submitted to:

New Jersey Department of Banking and Insurance
Office of Property/Casualty
20 West State Street
PO Box 325
Trenton, NJ 08625-0325
Attn: Automobile Premium Comparison Survey

Administrative change.

See: 30 N.J.R. 1317(a).

11:3-45.4 Penalties

Failure to comply with the provisions of this subsection shall result in the imposition of penalties as prescribed by law.

Amended by R.1999 d.218, effective July 19, 1999.
See: 31 N.J.R. 920(a), 31 N.J.R. 1927(a).

In (c), inserted N.J.S.A. reference at the beginning, and changed the date from December 31, 2000 to November 1, 2003 at the end.

11:3-46.2 Definitions

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

“Automobile” means an automobile as defined pursuant to N.J.S.A. 39:6A-2.

“Automobile insurance” means personal lines private passenger automobile insurance.

“Automobile insurance urban enterprise zone” or “UEZ” means a geographic area identified and designated by the Commissioner pursuant to N.J.S.A. 17:33C-2 and this subchapter.

“Automobile insurance urban enterprise zone program” or “program” means an automobile insurance urban enterprise zone program established pursuant to N.J.S.A. 17:33C-2 and this subchapter.

“Automobile insurer” means an insurer or group of affiliated insurers authorized or admitted to transact the business of personal lines private passenger automobile insurance in this State.

“Bona fide office” means an office maintained by the producer for the transaction of business that is open to the public during normal business hours, and that provides access as required by 12 U.S.C. § 12101 (the “Americans with Disabilities Act”).

“CAIP” means the Commercial Automobile Insurance Plan established pursuant to N.J.S.A. 17:29D-1 and N.J.A.C. 11:3-1.

“Commissioner” means the Commissioner of the New Jersey Department of Banking and Insurance.

“Department” means the New Jersey Department of Banking and Insurance.

“Insurance producer” means any person engaged in the business of an insurance agent, insurance broker, or insurance consultant, and who is licensed pursuant to N.J.S.A. 17:22A-1 et seq.

“Located in a UEZ” or “maintain a bona fide office in a UEZ” means that the street address of the business office of the producer is located in a zip code located within a UEZ. Determination of zip code boundaries shall be based on the edition of the United States Zip Code and Post Office Directory in effect at the time of the application for eligibility.

“PAIP” means the New Jersey Personal Automobile Insurance Plan established pursuant to N.J.S.A. 17:29D-1 and N.J.A.C. 11:3-2.

“Qualified insurer” means an automobile insurer that is a qualified insurer pursuant to N.J.S.A. 17:33C-3 and this subchapter.

“Urban enterprise zone agent” or “UEZ agent” means an insurance producer who is licensed pursuant to N.J.S.A. 17:22A-1 et seq., is appointed on or after January 1, 1998 by a qualified insurer in accordance with the procedures set forth in N.J.S.A. 17:22A-15 and N.J.A.C. 11:17-2.9 to represent it in an automobile insurance urban enterprise zone under the terms of N.J.S.A. 17:33C-1 et seq., and maintains a bona fide office within that automobile insurance urban enterprise zone.

Amended by R.2008 d.380, effective December 15, 2008 (operative January 1, 2009).

See: 40 N.J.R. 3572(a), 40 N.J.R. 6970(b).

Deleted definition “Eligible person”.

11:3-46.3 Designation of UEZ and UEZ share

(a) Pursuant to N.J.S.A. 17:33C-2, the Commissioner has identified and designated as UEZs certain urban-based geographic areas where the Commissioner has found that automobile insurance consumers would benefit from increased access to automobile insurance as set forth below. UEZs shall be designated by municipality consisting of one or more zip codes.

(b) In determining UEZ areas, the Commissioner first determined those areas of the State that are urban, as follows:

1. The eight Urban Centers designated by the State Planning Commission, Appendix C in the most recent edition of the State Plan; and

2. Municipalities with populations in excess of 10,000 as of the 1990 census and with population densities in excess of 3,500 persons per square mile.

(c) From the urban areas of the State pursuant to (b) above, the Commissioner has designated the UEZs using the following criteria:

1. Municipalities where less than half of the insurers with a Statewide marketshare of at least 0.5 percent have a marketshare in the municipality that is at least equal to 90 percent of their Statewide marketshare; and which are either:
 - i. Located in those rating territories where the pure premium for business in that territory divided by the pure premium for business in all territories exceeds 1.35, based on the data from the Department’s statistical agents for calendar-accident years 1993 through 1995 evaluated as of March 31, 1996;

ii. Designated as an Urban Center by the State Planning Commission, Appendix C in the 1992 edition of the New Jersey State Development and Redevelopment Plan; or

iii. Designated in the top 20 distressed municipalities by the State Planning Commission, in the 1996 Municipal Distress Index, Appendix B in the 1992 edition of the New Jersey State Development and Redevelopment Plan.

(d) The initial UEZ areas determined pursuant to (b) and (c) above are set forth in Exhibit A in the Appendix to this subchapter, incorporated herein by reference.

(e) The Commissioner shall, in consultation with the UEZ Advisory Committee established pursuant to N.J.S.A. 17:33C-2b, periodically review the availability of automobile insurance in this State and determine whether any revisions to the designation of UEZ areas are necessary to further the intent of N.J.S.A. 17:33C-1 et seq.

(f) The Commissioner shall advise each insurer of its UEZ share calculated as set forth in Exhibit B in the Appendix to this subchapter, incorporated herein by reference, by Order on or about November 15 of each year.

1. An insurer's initial UEZ share shall be based on each insurer's in-force exposures in UEZs reported for the period ended September 30, 1997. Subsequent UEZ shares shall be based on in-force exposures for the period ended September 30 of each year thereafter.

Amended by R.1999 d.218, effective July 19, 1999.
See: 31 N.J.R. 920(a), 31 N.J.R. 1927(a).
Rewrote (c).

11:3-46.4 Qualified insurers

(a) An automobile insurer may apply to the Commissioner to be considered a qualified insurer for purposes of participating in the UEZ program. An automobile insurer seeking to become a qualified insurer shall demonstrate that it will actively conduct business in UEZ areas by filing plans and procedures, including, but not limited to, the following:

1. A plan to increase access to automobile insurance for consumers residing in a UEZ;

2. A plan to assist newly appointed UEZ agents in developing the skills necessary to manage a successful business;

3. Procedures to monitor and evaluate the impact of efforts to expand services to urban areas;

4. Materials designed to assist consumers in understanding automobile insurance coverages;

5. The insurer's marketing plans and goals for increasing its writing of risks in automobile insurance urban enterprise zones; and

6. A certification from the insurer that it will file all reports required by this subchapter.

(b) The documents submitted pursuant to (a) above shall set forth with specificity:

1. The insurer's goal, which shall be the number of in-force exposures needed to meet its UEZ share, as calculated pursuant to N.J.A.C. 11:3-46.3(f).

i. In the case of an insurer that has been approved by the Department to limit coverage to persons who are members or employees of members of certain groups, clubs or organizations, such as trade associations or the military (so-called membership companies) when membership is a condition for insurance and is uniformly and consistently applied on a Statewide basis, its goal shall be to increase accessibility and marketshare in UEZs so that it insures at least the same percentage of potential eligible members in UEZs as its percentage marketshare of eligible members located outside the UEZs. The insurer also shall be able to demonstrate the potential number of eligible members in and outside the UEZs with credible data;

2. The number of in-force exposures projected to be written in the UEZs and Statewide for each quarter for the periods ending March 31, June 30, September 30, and December 31, which shall consider reductions in actual in-force writings due to nonrenewal, lapse, cancellations, etc.;

3. The UEZs in which the insurer intends to write or increase its writings;

4. The manner by which the insurer intends to satisfy its goal of increasing writings in UEZs, such as appointment of UEZ agents; use of existing agents; new marketing initiatives; etc.;

5. A listing of UEZ agents appointed to date, together with any limit on the number of exposures the UEZ agents may write, pursuant to N.J.S.A. 17:33C-4; and

6. If UEZ agents will be utilized, the support services to be provided to those agents to write the business and whether support services to be provided are different than those provided to its agents appointed in the ordinary course of business.

(c) All qualified insurers and insurers filing for qualification shall keep current the information required as part of an application for qualification by filing with the Department any changes in the information filed pursuant to (b) above no later than 15 days after such change.

(d) An automobile insurer that meets the applicable standards established pursuant to (a) above shall certify to the Commissioner that it is a qualified insurer and shall certify to the specific provisions set forth in its plan pursuant to (b) above.

(e) An automobile insurer that certifies to the Commissioner pursuant to (d) above that it meets the standards established pursuant to (a) and (b) above shall be a qualified insurer. If upon review of the documents filed the Commissioner determines that the plan fails to provide all of the information required pursuant to (a) and (b) above, the Commissioner shall promptly notify the insurer that its filing is incomplete, and that it shall not be considered a qualified insurer until the deficiencies in the filing are addressed.

(f) Only qualified insurers shall be eligible to participate in the UEZ program.

(g) To the extent an insurer, in order to provide a complete plan to be a qualified insurer, submits proprietary information, the insurer shall identify and include such information on separate documents. Proprietary information shall be confidential and shall not be subject to public inspection or copying pursuant to the "Open Public Records Act", N.J.S.A. 47:1A-1 et seq. If the Department determines that such information is not proprietary, the Department shall notify the insurer prior to responding to any public records request.

Amended by R.2008 d.380, effective December 15, 2008 (operative January 1, 2009).

See: 40 N.J.R. 3572(a), 40 N.J.R. 6970(b).

In the introductory paragraph of (b)1, substituted a period for a semicolon at the end; rewrote (b)1i; and in (g), substituted "'Open Public Records Act'" for "'Right-to-Know' law".

11:3-46.5 UEZ agents

(a) A qualified insurer may appoint one or more UEZ agents on or after January 1, 1998. Such appointments shall comply with all requirements set forth in N.J.S.A. 17:33C-4 and 17:22A-15, N.J.A.C. 11:17-2.9, and this subchapter. UEZ agent contracts shall set forth any limitation on the number of exposures that may be written by the UEZ agent pursuant to N.J.S.A. 17:33C-4. The notice of agency contract filed pursuant to N.J.A.C. 11:17-2.9 shall note that the agent is a UEZ agent whose contract includes provisions permitted by N.J.S.A. 17:33C-1 et seq. and this subchapter.

(b) The insurer shall provide UEZ agents with reasonable support services. In addition, in setting the compensation for UEZ agents, the insurer shall comply with N.J.S.A. 17:33B-18b.

(c) If the qualified insurer is a direct writer (that is, an insurer that writes business directly through its own employees without the use of contracted agents), and has an amount of in-force exposures in UEZs that exceeds 105 percent of its Statewide marketshare as of the end of a quarterly reporting period, it may request that the Commissioner permit the insurer to suspend any additional marketing efforts implemented as part of its plan submitted pursuant to N.J.A.C. 11:3-46.4.

11:3-46.6 PAIP voluntary rating tier

(a) Pursuant to N.J.S.A. 17:29D-1i, the PAIP Plan of Operation shall provide for the establishment of a voluntary rating tier in which persons residing in UEZs may be written by certain UEZ agents and qualified producers, as set forth in N.J.A.C. 11:3-46.7. The rates utilized in the voluntary rating tier shall be the voluntary market rates in use by the insurer to which the risk is distributed.

(b) The voluntary rating tier shall not provide insurance coverage for more than five percent of the aggregate number of private passenger automobile non-fleet exposures being written in the total private passenger automobile insurance market in this State. The number of exposures written in the voluntary rating tier shall be included for purposes of determining the maximum number of overall exposures permitted to be written in the PAIP pursuant to N.J.S.A. 17:29D-1d. The Commissioner may suspend writings in the voluntary rating tier if he or she finds that total amount of exposures written in the PAIP is approaching the maximum amount permitted to be written in the PAIP pursuant to N.J.S.A. 17:29D-1d.

(c) An insurer that does not meet its goal, for qualified insurers, or UEZ share, for insurers that are not qualified insurers, shall be subject to distributions in an amount required for the insurer to meet its goal or UEZ share, as applicable, evaluated based on the insurer's quarterly reports filed pursuant to N.J.A.C. 11:3-46.13 in accordance with (f) below.

(d) Insurers that have, and maintain, an aggregate voluntary private passenger automobile insurance marketshare in UEZs that is at least 95 percent of the insurer's goal, if a qualified insurer, or UEZ share, if not a qualified insurer, shall be exempt from distributions pursuant to this section.

(e) An insurer shall be subject to initial distributions beginning September 1, 1998 unless the insurer has filed a plan to become a qualified insurer pursuant to N.J.A.C. 11:3-46.4 by July 1, 1998 that provides as a goal to eliminate its shortfall by March 31, 1999; and either:

1. Has written an amount of in-force exposures equal to at least 20 percent of its goal by June 30, 1998; or

2. Has filed a report with the Department prior to September 1, 1998 that demonstrates that the insurer has written an amount of in-force exposures equal to at least 30 percent of its goal as of September 1, 1998.

(f) An insurer shall be subject to subsequent distributions of exposures if it fails to maintain its goal as of June 30 and each calendar quarter thereafter following the establishment of the UEZ share, based on the report of in-force exposures filed pursuant to N.J.A.C. 11:3-46.13. The Department shall monitor the amount of an insurer's in-force writings quarterly to determine whether it is or remains subject to distributions.

(e) Qualified producers shall not accept multiple applications from the same applicant. The producer shall not submit an application on behalf of an applicant that has applied to the voluntary rating tier within the immediately preceding 30 days.

(f) The PAIP may apportion the number of exposures that may be written among UEZ agents and qualified producers. Such apportionment shall be based on the number of UEZ agents and qualified producers, the number of exposures available to be distributed, and the limit on the number of exposures that may be written through the voluntary rating tier.

(g) The PAIP shall reject and not distribute any risk produced from a UEZ agent or qualified producer that fails to satisfy the requirements of N.J.A.C. 11:3-46.7.

11:3-46.12 PAIP Plan of Operation

(a) The PAIP shall develop any amendments or supplements to the PAIP Plan of Operation as may be necessary or appropriate to provide for the implementation of N.J.A.C. 11:3-46.6, 46.7, 46.8, 46.9, 46.10, and 46.11. Such amendments or supplements shall be subject to review and approval by the Commissioner pursuant to N.J.A.C. 11:3-2.6.

(b) The PAIP governing committee shall submit to the Commissioner, for his or her approval, such amendments and supplements to the Plan of Operation no later than July 1, 1998. If the governing committee does not submit amendments or supplements within the time set forth in (a) above, or amendments or supplements acceptable to the Commissioner within 30 days after disapproval of the proposed changes, the Commissioner may promulgate such amendments or supplements and certify same to the governing committee.

11:3-46.13 Reporting requirements

(a) Each automobile insurer shall report on a quarterly basis its in-force private passenger automobile exposures in UEZs by zip code for the periods ending March 31, June 30, September 30, and December 31. Such reports shall be filed within 10 days of the end of each quarter and shall be in the form set forth in Exhibit C in the Appendix to this subchapter, incorporated herein by reference.

(b) In addition to (a) above, the Commissioner may from time to time order insurers to file in-force exposure data by zip code for all urban areas, regardless of whether those areas are currently designated as UEZs.

(c) Reports filed pursuant to this section shall be confidential and shall not be subject to public inspection or copying pursuant to the "Right-to-Know" law, N.J.S.A. 47:1A-1 et seq.

(d) All reports filed pursuant to this section shall be filed with the Department at the following address:

New Jersey Department of Banking and Insurance
Office of Property and Casualty
PO Box 325
Trenton, NJ 08625-0325

Amended by R.1999 d.218, effective July 19, 1999.
See: 31 N.J.R. 920(a), 31 N.J.R. 1927(a).
In (a), rewrote the last sentence.

11:3-46.14 Penalties

Failure to comply with this subchapter shall result in the imposition of penalties as authorized by law, including, but not limited to, a penalty up to \$1,000 for a first violation, and up to \$2,000 for each subsequent violation, pursuant to N.J.S.A. 17:33-2; and a fine up to \$25,000, or suspension or revocation of an insurer's certification as a qualified insurer, pursuant to N.J.S.A. 17:33C-3c.

APPENDIX

Exhibit A

<u>Zip Code</u>	<u>Town</u>	<u>County</u>	<u>Territory</u>
07302	Jersey City	Hudson	1
07303	Jersey City	Hudson	1
07304	Jersey City	Hudson	1
07305	Jersey City	Hudson	1
07306	Jersey City	Hudson	1
07307	Jersey City	Hudson	1
07309	Jersey City	Hudson	1
07310	Jersey City	Hudson	1
07311	Jersey City	Hudson	1
07047	N. Bergen	Hudson	1
07087	Union City/Weehawken	Hudson	1
07093	West New York/Guttenberg	Hudson	1
07101	Newark	Essex	2
07102	Newark	Essex	2
07103	Newark	Essex	2
07104	Newark	Essex	2
07105	Newark	Essex	2
07106	Newark	Essex	2
07107	Newark	Essex	2
07108	Newark	Essex	2
07112	Newark	Essex	2
07114	Newark	Essex	2
07011	Clifton	Passaic	3
07012	Clifton	Passaic	3
07013	Clifton	Passaic	3
07014	Clifton	Passaic	3
07026	Garfield	Bergen	3
07506	Hawthorne	Passaic	3
07507	Hawthorne	Passaic	3
07424	Little Falls/W. Paterson	Passaic	3
07055	Passaic	Passaic	3
07501	Paterson	Passaic	3
07502	Paterson	Passaic	3
07503	Paterson	Passaic	3
07504	Paterson	Passaic	3
07505	Paterson	Passaic	3
07509	Paterson	Passaic	3
07510	Paterson	Passaic	3
07513	Paterson	Passaic	3
07514	Paterson	Passaic	3
07522	Paterson	Passaic	3
07524	Paterson	Passaic	3

Zip Code	Town	County	Territory
07533	Paterson	Passaic	3
07543	Paterson	Passaic	3
07544	Paterson	Passaic	3
07057	Wallington	Bergen	3
07201	Elizabeth	Union	4
07202	Elizabeth	Union	4
07206	Elizabeth	Union	4
07207	Elizabeth	Union	4
07208	Elizabeth	Union	4
08601	Trenton	Mercer	6
08602	Trenton	Mercer	6
08603	Trenton	Mercer	6
08605	Trenton	Mercer	6
08607	Trenton	Mercer	6
08608	Trenton	Mercer	6
08609	Trenton	Mercer	6
08611	Trenton	Mercer	6
08618	Trenton	Mercer	6
08629	Trenton	Mercer	6
08638	Trenton	Mercer	6
08030	Gloucester	Camden	7
08101	Camden	Camden	7
08102	Camden	Camden	7
08103	Camden	Camden	7
08104	Camden	Camden	7
08105	Camden	Camden	7
08861	Perth Amboy	Middlesex	8
08862	Perth Amboy	Middlesex	8
08401	Atlantic City	Atlantic	19
07109	Belleville	Essex	22
07111	Irvington	Essex	22
07017	E. Orange	Essex	38
07018	E. Orange	Essex	38
07019	E. Orange	Essex	38
07050	Orange City	Essex	38
07051	Orange City	Essex	38
07061	Plainfield	Union	39
07062	Plainfield	Union	39
07063	Plainfield	Union	39
08901	New Brunswick	Middlesex	40
08903	New Brunswick	Middlesex	40
08906	New Brunswick	Middlesex	40

Exhibit B

Calculation of UEZ Shares:

1. In-Force Exposures reported by zip code are combined for individual companies that are part of a group. Also, the in-force exposures reported for individual zip codes are combined for all UEZs.

2. The "Statewide Market Share" for an automobile insurer is calculated by dividing the total number of in-force exposures reported on the quarterly in-force report minus the total number of exposures in UEZs as of September 30 by the total number of in-force exposures in the state.

3. The "Individual UEZ Share" is the number of exposures a company or group should be writing in all UEZs combined. The Individual UEZ Share is calculated by multiplying an automobile insurer's statewide market share times the total number of exposures in all the UEZ's.

4. Each automobile insurer's "Individual UEZ Shortfall" is calculated by subtracting the number of its in-force exposures in all UEZs from its Individual UEZ share. A negative number indicates that the company exceeded its statewide market share in that UEZ.

Example:

To illustrate how these calculations are made, the example below uses two automobile insurers. Group A consists of Company 1 and Company 2. Company B is a single company. Two municipalities, E. Orange and Elizabeth, are used in the example to represent all UEZs.

In-Force Exposures Reported to Department

Zip Code	Town	Group A		Group A total	Company B
		Company 1	Company 2		
07017	E. Orange	91	7	98	38

Zip Code	Town	Company 1	Company 2	Group A total	Company B
07018	E. Orange	39	10	49	24
07019	E. Orange	4	6	10	8
	total			157	70
07201	Elizabeth	4	6	10	78
07202	Elizabeth	71	13	84	253
07206	Elizabeth	114	13	127	61
07207	Elizabeth	14	0	14	136
07208	Elizabeth	7	2	9	125
	total			244	653

In-Force Exposures for Individual Zip Code and Insurer Groups Combined

	Group A	Company B	Total In-Force Exposures in UEZ
All UEZs	401	723	60,000

Calculation of Statewide Market Share

	Group A	Company B	Total In-Force Exposures in State
total in-force	342,000	49,000	4,400,000
less UEZs	401	723	
market share	5.51%	1.10%	

Calculation of Individual UEZ Shares

UEZ share	Group A	Company B
	3,295	658

Calculation of Individual UEZ Shortfalls

	Group A	Company B
UEZ in-force	401	723
UEZ Share	3,295	658
Total Shortfall	2,894	- 65

Exhibit C

**UEZ QUARTERLY IN-FORCE EXPOSURE REPORT
REQUIRED BY N.J.A.C. 11:3-4**

Company Name _____
 NAIC # _____ Group # _____
 Report for Quarter Ending _____
 199 _____
 Number of Companies Reporting in Group _____
 Name of Contact Person _____
 Telephone/e-mail _____

Zip Code	UEZ	UZAR		
		Voluntary In-Force Exposures	Assigned In-Force Exposures	Total In-Force Exposures
07011	Clifton			
07012	Clifton			
07013	Clifton			
07014	Clifton			
07017	E. Orange			
07018	E. Orange			
07019	E. Orange			
07026	Garfield			
07047	N. Bergen			
07050	Orange City			
07051	Orange City			
07055	Passaic			
07057	Wallington			
07061	Plainfield			
07062	Plainfield			
07063	Plainfield			
07087	Union City/Weehawken			
07093	West New York/ Guttenberg			
07101	Newark			
07102	Newark			
07103	Newark			
07104	Newark			
07105	Newark			
07106	Newark			

Zip Code	UEZ	UZAR			Zip Code	UEZ	UZAR		
		Voluntary In-Force Exposures	Assigned In-Force Exposures	Total In-Force Exposures			Voluntary In-Force Exposures	Assigned In-Force Exposures	Total In-Force Exposures
07107	Newark				07543	Paterson			
07108	Newark				07544	Paterson			
07109	Belleville				08030	Gloucester			
07111	Irvington				08101	Camden			
07112	Newark				08102	Camden			
07114	Newark				08103	Camden			
07201	Elizabeth				08104	Camden			
07202	Elizabeth				08105	Camden			
07206	Elizabeth				08401	Atlantic City			
07207	Elizabeth				08601	Trenton			
07208	Elizabeth				08602	Trenton			
07302	Jersey City				08603	Trenton			
07303	Jersey City				08605	Trenton			
07304	Jersey City				08607	Trenton			
07305	Jersey City				08608	Trenton			
07306	Jersey City				08609	Trenton			
07307	Jersey City				08611	Trenton			
07309	Jersey City				08618	Trenton			
07310	Jersey City				08629	Trenton			
07311	Jersey City				08638	Trenton			
07424	Little Falls/W. Paterson				08861	Perth Amboy			
07501	Paterson				08862	Perth Amboy			
07502	Paterson				08901	New Brunswick			
07503	Paterson				08903	New Brunswick			
07504	Paterson				08906	New Brunswick			
07505	Paterson					Total			
07506	Hawthorne								
07507	Hawthorne								
07509	Paterson								
07510	Paterson								
07513	Paterson								
07514	Paterson								
07522	Paterson								
07524	Paterson								
07533	Paterson								

Amended by R.1999 d.218, effective July 19, 1999.
 See: 31 N.J.R. 920(a), 31 N.J.R. 1927(a).
 In Exhibit A, inserted references to the towns of Perth Amboy and Plainfield; and added Exhibit C.

SUBCHAPTER 47. (RESERVED)