

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Fifth Avenue Surgery Center LLC
(Applicant)

- and -

Allstate Fire & Casualty Insurance Company
(Respondent)

AAA Case No. 17-19-1122-3597

Applicant's File No. SS-104327

Insurer's Claim File No. 0476245337
2AM

NAIC No. 29688

ARBITRATION AWARD

I, Kevin R. Glynn, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD**:

Injured Person(s) hereinafter referred to as: Assignor

1. Hearing(s) held on 04/16/2020
Declared closed by the arbitrator on 04/16/2020

Greg Itingen, Esq. from Samandarov & Associates, P.C. participated in person for the Applicant

Tom Cook, Esq. from Law Offices of John Trop participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 3,357.37**, was NOT AMENDED at the oral hearing.
Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The Assignor, IK, is a 47yo male who was injured in a motor vehicle accident on 9/24/17. IK suffered injuries which resulted in his seeking treatment. In dispute is the Applicant's claim regarding a facility fee for a left shoulder arthroscopic surgery (23430 LT, 29821 LT 59, 29823 LT 59, 29825 LT 59, 29999 LT 59) performed on 7/2/18, in the total amount of \$9,001.51. Respondent partially paid the claim in the amount of \$5,644.14, leaving an amount in dispute of \$3,357.37, pursuant to a fee schedule defense. Therefore, the issue is if Respondent can sustain its fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the Parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived.

Applicant submitted its facility claim regarding a left shoulder arthroscopic surgery performed on 7/2/18, in the total amount of \$9,001.51. The specific charges were under CPT codes 23430 LT in the amount of \$3,111.71; 29821 LT 59, in the amount of \$1,472.45; 29823 LT 59, in the amount of \$1,472.45; 29825 LT 59, in the amount of \$1,472.45; and, 29999 LT 59, in the amount of \$1,472.45. Respondent partially paid code 23430 LT in the amount of \$904.71; code 29821 in the amount of \$889.82; code 29823 in the full amount of \$1,472.45; code 29825 in the full amount of \$1,472.45; and, code 29999 in the partial amount of \$904.71. Respondent states in its denial:

X21 In accordance to New York No-Fault Law, Regulation 68, this base fee was calculated according to the New York Workers' Compensation Board Schedule of Fees, pursuant to Regulation 83 and/or Appendix 17-C of 11 NYCRR. X52 When multiple procedures, unrelated to the major procedure and adding significant time or complexity are provided at the same operative session, payment is for the procedure with the highest allowance, plus half of the lesser procedures (New York Workers' Compensation Medical Fee Schedule, Surgery Ground rule 5, revised 4/1/2003).

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip Op 26240, 12 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that an Applicant's claims were in excess of the appropriate fee schedule, Respondent's defense of noncompliance with the appropriate fee schedule cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curiam, 2006).

Respondent amends its fee schedule defense with the Signet Claim Solutions, LLC Fee Schedule Affidavit by Beth Seidman, CPC, dated 4/8/19. Ms. Seidman presents an APG analysis in which she determined the total amount due was \$4,541.41. Specifically, Ms. Seidman opines:

... The provider incorrectly coded CPT 29999 (Unlisted procedure, arthroscopy). As per Operative report Patient [IK], date of surgery 07/02/2018. Left Shoulder Arthroscopy, CPT code 29999 (Unlisted procedure, arthroscopy) was documented for Lysis of coracoacromial ligament. The correct CPT code is 29826 LT (Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when

performed (List separately in addition to code for primary procedure). CPT code 29826 has an APG of 37 and is considered consolidated as per EAPG Guidelines to "Significant Procedure 29823 LT. CPT codes 29826, 29999, 29821, and 29825 are considered consolidated as per EAPG Guidelines "Significant Procedure Consolidation", therefore Reimbursement is \$0.00

... CPT Code: 23430 is an additional Significant Procedure Performed

... The APG assignment code for the significant procedures performed is 31 and the EAPG weight assigned = $10.2397 \times \$295.94$ (base rate for downstate) = $\$3,030.34 @ 50\% = \$1,515.17$

Modifier 59 has been appended in error to CPT codes 29821, 29823, 29825 and 29999.

As per CPT, modifier 59 is to be appended to a CPT code when a distinct procedural service is performed. As per CPT guidelines on the use of modifier 59, documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same individual.

Total Including Capital Add-On:

APG 37 = $\$2,944.87$ + APG 31 = $\$1,515.17$ + Capital Add-On 81.37 = $\$4,541.41$

In response to Respondent's affidavit, Applicant submits a Code Review Affirmation by Aaron J. Perretta, Esq., CPC, dated 4/15/20. Mr.Perretta rebuts the opinion of Ms. Seidman, stating:

... In this matter, Seidman improperly imports her layperson musings, opining the services represented by CPT Code 29999 and are better represented by CPT Code 29826. Specifically, Seidman states CPT Code 29999 was coded "incorrectly code" cites to a specific portion of the operative report she believes supports her position, and opines "The correct CPT code is 29826 LT ." See Seidman, p. 4... However, Respondent never offers Seidman as an expert medical professional or as an individual possessing the requisite expertise on the subject surgical procedures. In fact, Seidman explicitly states on page 2 of her fee audit, "This auditor is not a medical professional [...]." Thus, Seidman cannot state with any persuasive authority or as a medical expert possessing the

requisite knowledge and expertise that based upon her layperson review of the operative report, services reported by CPT Code 29999 are

better served by CPT Code 29826... In regards to CPT Code 29999 specifically - which represents the lysis of coracromial ligament - Applicant finds it troubling Seidman states it was coded "in error," when it is plainly obvious from reading the actual operative report that "Left Shoulder arthroscopic lysis of the coracoacromial ligament" is denoted in the "PROCEDURES PERFORMED" subheading of the operative report on the first page, and that the body of the report states on the second page, "...A thickened hypertrophic CA ligament was noted off the anterolateral aspect of the acromion and the CA ligament was taken down using the shaver and ArthroCare wand via the anterior portal site. Any bleeding vessels were cauterized using the ArthroCare wand via the anterior portal site. This concluded our lysis of the CA ligament." See EXHIBIT A. Thus, it is clear that CPT Code 29999 was properly utilized to represent these procedures. CPT Code 29826 - which represents a decompression of subacromial space with partial acromioplasty, with coracromial ligament release, was not described by the operative report. See EXHIBIT A. Since Seidman is not a medical professional, Applicant cannot fathom why Seidman believes CPT Code 29826 should be reported for the services when 29999 was used to represent those services performed which were not adequately described by any existing CPT code... Because Seidman fails to properly demonstrate the downcoding of CPT Code 29999 to 29826, Respondent's rate of reimbursement defense fails in this regard... In regards to CPT Codes 29821, 29825 and 29999 (again, of which Seidman improperly down codes to 29826), Seidman explicitly argues these CPT Codes are not entitled to reimbursement, in part because, "CPT Codes 29826, 29999, 29821 and 29825 are consolidated as per EAPG Guidelines "Significant Procedure Consolidation," therefore reimbursement is \$0.00." See Seidman p. 4. In other words, Seidman is arguing the aforementioned CPT Codes assigned EAPG Procedure Code 37 must all be consolidated into CPT Code 29823, which Seidman determines is the main procedure assigned to EAPG Procedure Code 37... As was stated above, the unbundling power of Modifier 59 is squarely supported by the New York State Workers' Compensation Board via the EAPG framework. Per the aforementioned Presentation, it explicitly states on page 18 that Modifier 59 "Turns off consolidation - allows separate payment. See EXHIBIT D.

As also stated above, this 50% charge is further exemplified by the APG Provider Manual, annexed hereto as EXHIBIT E, stating under the definition of Modifier 59 on page 14, Seidman further argues Modifier 59 was improperly appended to CPT Codes 29821, 29823, 29825 and 29999, arguing, "As per CPT guidelines on the use of modifier 59, documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion or separate injury not ordinarily encountered or performed on the same day by the same individual." See Seidman, p. 5... Yet, the very argument Seidman puts forth in her fee audit actually supports Applicant's position that Modifier 59 is properly applied in this instance, since it borrows identical language from the very coding resource Applicant relies upon to support Modifier 59's use... It must be stressed 1) the AMA's description of Modifier 59 does not automatically preclude its use if the services at issue are performed upon the same body part, and 2) the definition Seidman puts forth regarding Modifier 59 in both her fee review specifically includes the phrases "different procedure" and "separate incision/excision," which are clearly prevalent in the universally-adopted AMA definition above. Applicant's bill and operative report stand for the position that its use of Modifier 59 in

this instance permits CPT Codes 29821, 29823, 29825, and 29999 to be properly coded with CPT Code 23430, per the AMA's descriptor of same. Per the operative report previously uploaded to MODRIA and annexed hereto as EXHIBIT A for this arbitrator's convenience, it is clear three separate incisions were performed upon the patient at the posterolateral, lateral, and anterior portal sites ("Posterolateral, lateral, and anterior portal sites were established"). Furthermore, five different procedures were performed on different parts of the patient's right shoulder, as denoted under the "PROCEDURES PERFORMED" section of the operative report. Annexed hereto as EXHIBIT I are various awards penned by Arbitrators Barry, Jacob, Russo, Andreotta, Abraham-LoFurno, who all hold Modifier 59 is appropriately utilized when separate incisions are created and multiple procedures are executed during one surgical setting... Furthermore, at no point did Respondent ever issue verification requests concerning the use of this Modifier pursuant to 11 NYCRR §§ 65-3.5, 65-3.6(b), and never requested any additional information concerning why Modifier 59 was utilized to more accurately represent services rendered... Thus, because Seidman fails to "conclusively demonstrate" in a coherent manner"

Applicant's use of Modifier 59 is improper, Seidman fails to shift the burden or prove these CPT Codes may not be reimbursed at the amounts denoted in the rubric supra... The total amount in dispute for the services rendered in New York pursuant to the EAPG framework is the balance of \$3,357.37.

Submitted with Mr. Perretta's affidavit is a 3M Health Information Systems EAPG calculation printout supporting his opinion that the amount billed was correct pursuant to the EAPG Guidelines.

I find Code Review Affirmation by Mr. Perretta and the exhibits annexed thereto, to be more persuasive than the fee schedule analysis presented by Ms. Seidman. Applicant has established that it billed at the proper rate. Accordingly, Applicant is awarded reimbursement of the disputed claim amount of \$3,357.37.

5. Optional imposition of administrative costs on Applicant.
Applicable for arbitration requests filed on and after March 1, 2002.

I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**

- ☐ The policy was not in force on the date of the accident
- ☐ The applicant was excluded under policy conditions or exclusions
- ☐ The applicant violated policy conditions, resulting in exclusion from coverage
- ☐ The applicant was not an "eligible injured person"
- ☐ The conditions for MVAIC eligibility were not met
- ☐ The injured person was not a "qualified person" (under the MVAIC)
- ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
- ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Status
	Fifth Avenue Surgery Center	07/02/18 - 07/02/18	\$3,357.37	Awarded: \$3,357.37
Total			\$3,357.37	Awarded: \$3,357.37

- B. The insurer shall also compute and pay the applicant interest set forth below. 01/30/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

In the instant matter Applicant is awarded interest pursuant to the no-fault regulations. 11 NYCRR 65-3.9 (a) provides that Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." Pursuant to 11 NYCRR 65-3.9 (c), "if an applicant does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Department of Financial Services regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken." Applicant electronically submitted its claim for arbitration on 1/30/19, more than thirty days after receipt of the denial of claim dated 8/30/17. Therefore, interest shall run effective 1/30/19.

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below

An attorney's fee of 20% shall be paid on the sum of the awarded claim plus interest, subject to a maximum of \$1,360.00.

- D. The respondent shall also pay the applicant forty dollars (\$40) to reimburse the applicant for the fee paid to the Designated Organization, unless the fee was previously returned pursuant to an earlier award.

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York

SS :

County of Nassau

I, Kevin R. Glynn, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

05/11/2020

(Dated)

Kevin R. Glynn

IMPORTANT NOTICE

This award is payable within 30 calendar days of the date of transmittal of award to parties.

This award is final and binding unless modified or vacated by a master arbitrator. Insurance Department Regulation No. 68 (11 NYCRR 65-4.10) contains time limits and grounds upon which this award may be appealed to a master arbitrator. An appeal to a master arbitrator must be made within 21 days after the mailing of this award. All insurers have copies of the regulation. Applicants may obtain a copy from the Insurance Department.

ELECTRONIC SIGNATURE

Document Name: Final Award Form
Unique Modria Document ID:
de7acbceea9a55704b154c971633d7a6

Electronically Signed

Your name: Kevin R. Glynn
Signed on: 05/11/2020