

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Dynamic Surgery Center, LLC , Premier
Anesthesia Associates PA
(Applicant)

- and -

AAA Case No. 17-19-1119-0751

Applicant's File No. None

Insurer's Claim File No. 322398C67

NAIC No. 25178

State Farm Mutual Automobile Insurance
Company
(Respondent)

ARBITRATION AWARD

I, Paul Weidenbaum, 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: IP

1. Hearing(s) held on 09/24/2020
Declared closed by the arbitrator on 09/24/2020

Dino Di Rienzo from Dino R. DiRienzo Esq. participated in person for the Applicant

Jonathan De Pasquale from James F. Butler & Associates participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 2,345.29**, 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

This arbitration arises out of medical services provided to the injured person, a 33 year old female, who was involved in a motor vehicle accident which occurred on 12/16/17.

Whether Respondent's reduction/denial of the Applicant's claim for reimbursement of No-Fault benefits based on fee schedule can be sustained?

4. Findings, Conclusions, and Basis Therefor

This arbitration arises out of surgical services provided to the injured person, a 33 year old female, who was involved in a motor vehicle accident which occurred on 12/16/17. Applicant seeks reimbursement in the sum of \$2,345.29. Respondent denied further reimbursement based on fee schedule, and submitted the fee analysis prepared by Lisette Giffels, C.P.C. dated 5/5/19, in which Ms. Giffels concludes that the Respondent appropriately reimbursed Applicant for the services at issue per the applicable provisions of the fee schedule, and no further reimbursement is due, as follows:

"SUMMARY: NJ Fee Schedule: The service was provided in NJ. Per 11 NYCRR 68: PART 68 - CHARGES FOR PROFESSIONAL HEALTH SERVICES (Regulation 83) Section 68.6 Health services performed outside New York State If a professional health service reimbursable under section 5102(a)(1) of the Insurance Law is performed outside New York State, the permissible charge for such service shall be the prevailing fee in the geographic location of the provider. NJ has a statutory medical fee schedule: SUBCHAPTER 29. MEDICAL FEE SCHEDULES: AUTOMOBILE INSURANCE PERSONAL INJURY PROTECTION AND MOTOR BUS MEDICAL EXPENSE INSURANCE COVERAGE This review is to determine the allowable payment per the NJ medical fee schedule (facility fee) which would be the prevailing fee in the geographic location of the provider. Per the NJ Medical Fee Schedules: Automobile Insurance Personal Injury Protection and Motor Bus Medical Expense Insurance Coverage 11:3-29.4 Application of medical fee schedules (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. (d) When multiple procedures are performed in an 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. (g) Except as specifically stated to the contrary in this subchapter, the fee schedules shall be interpreted in accordance with the following, incorporated herein by reference, as amended and supplemented: the relevant chapters of the Medicare Claims Processing Manual, updated periodically by CMS, that were in effect at the time the service was provided. The Medicare Claims Processing Manual is available at <https://www.cms.gov/Manuals/IOM/itemdetail.asp?itemID=CMS018912>; the NCCI Policy Manual for Medicare Services, as updated periodically by CMS and available at http://www.cms.gov/NationalCorrectCodInitEd/Downloads/NCCI_Policy_Manual.zip Modifier 59 Article: Proper Usage Regarding Distinct Procedural Service, available from CMS at <https://www.cms.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf>; and the CPT Assistant available from the American Medical Association (www.AMAbookstore.com). Date of service 8/10/2018 (EOR dated 9/28/2018) amount billed = \$2,586.34: The provider billed CPT codes 64490 50, 64491 50,

64492 50. This is a facility charge • CPT code 64490 fee Northern NJ paid at 100% = \$1,012.32 • CPT code 64490 fee Northern NJ paid at 50% = \$506.16 • CPT code 64491 fee Northern NJ \$355.95 paid at 50% = \$177.98 • CPT code 64491 fee Northern NJ \$355.95 paid at 50% = \$177.97 • CPT code 64492 fee Northern NJ \$355.95 paid at 50% = \$177.98 • CPT code 64492 fee Northern NJ \$355.95 paid at 50% = \$177.97 Provider is in North Region per the zip of service 07663. The total allowable amount per the fee schedule is \$2,230.38 NY Fee Schedule Calculation per the 33rd Amendment to Regulation 83: Per the NY DFS: Frequently Asked Questions about Regulation 83 and the No-Fault Fee Schedule Q: What is the effective date of the 33rd Amendment to Regulation 83, and does it affect existing claims or only new claims? A: January 23, 2018. The changes effected by the 33rd Amendment to Regulation 83 would be applicable to claims with a date of service occurring on or after January 23, 2018. If a claim contains dates of service which are both prior to and after January 23, 2018, the portion of the claim incurred prior to that date would not be subject to the 33rd Amendment to Regulation 83, irrespective of the date of accident, or the date the bill was received by the insurer. The amended fee schedule for professional services [11 NYCRR 68.6 (b)] apply in this case since the DOS is 8/10/2018. Section 68.6. Health services performed outside New York State. (a)(1) If a professional health service reimbursable under [section 5102(a)(1) of the] Insurance Law section 5102(a)(1) is performed outside [New York] this State, the [permissible charge] amount that the insurer shall reimburse for [such] the service shall be the lower of the amount charged by the provider and the prevailing fee in the geographic location of the provider with respect to services: (i) that constitute emergency care; (ii) provided to an eligible injured person that is not a resident of this State; or (iii) provided to an eligible injured person that is a resident of this State who, at the time of treatment, is residing in the jurisdiction where the treatment is being rendered for reasons unrelated to the treatment. (2) For purposes of this subdivision, emergency care means all medically necessary treatment initiated within 48 hours of a motor vehicle accident for a traumatic injury or a medical condition resulting from the accident, which injury or condition manifests 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. Medically necessary treatment shall include immediate prehospitalization 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 the hospital. (b) Except as provided in subdivision (a) of this section, if a professional health service reimbursable under Insurance Law section 5102(a)(1) is performed outside this State with respect to an eligible injured person that is a resident of this State, the amount that the insurer shall reimburse for the service shall be the lowest of: (1) the amount of the fee set forth in the region of this State that has the highest applicable amount in the fee schedule for that service; (2) the amount charged by the provider; and (3) the prevailing fee in the geographic location of the provider. CPT codes billed: 64490 50, 64491 50, 64492 50. The provider submitted the charges using the revenue codes and CPT codes. A "crosswalk" was made to

determine the appropriate EAPG code.

Out-of-state facilities:

Bills submitted by out-of-state facilities should be reimbursed using the EAPG-based ambulatory surgery fee schedule. The Board will follow the Department of Health's guidance regarding out-of-state billing in the Policy and Billing Guidance Ambulatory Patient Groups Provider Manual Rates of payment for out-of-state providers in counties contiguous to New York City and New York's Dutchess, Putnam, Westchester, Rockland and Orange Counties will reflect the average APG payment for the same services applicable to New York State providers in those downstate areas. Outof-state counties contiguous to the downstate rate region include: Sussex, Passaic, Bergen, Hudson, Essex, Middlesex, Union and Monmouth Counties in New Jersey; Pike County in Pennsylvania; and Litchfield and Fairfield Counties in Connecticut. Rates of payment for all other out-of-state providers will reflect the average APG payment for the same services applicable to providers in upstate New York. The EAPG code for CPT code 64490 50, 64491 50 and 64492 50 is 220 and the EAPG weight assigned = $3.0358 \times \$295.94$ (base rate for downstate) = $\$898.41 \times 150\%$ (bilateral procedure) = $\$1,347.62$ (only one payment based on consolidation since both procedures are in the same EAPG group) • As per the APG provider manual, Significant Procedure Consolidation: Significant procedure consolidation refers to the collapsing of multiple related significant procedure APGs into a single APG for the purpose of determining payment. The APG system relies on a significant procedure consolidation list developed on the basis of clinical judgment which identifies for each significant procedure APG, the other significant procedure APGs that are an integral part of the procedure and which can be performed with relatively little additional effort. The APG grouping logic consolidates related significant procedures. (Example: a Level I (primarily diagnostic) lower gastrointestinal endoscopy is consolidated into the Level II (primarily therapeutic) gastrointestinal endoscopy.) Unrelated significant procedures are not consolidated. Multiple unrelated significant procedures on the same date of service also are not consolidated in the APG classification system, but payment for additional unrelated significant procedures will be discounted. Note: This modifier should not be used to report surgical procedures that are identified in code terminology as "bilateral" or to report procedures identified in code terminology as "unilateral or bilateral." When Modifier 50 is used, both procedures will be reimbursed, but the APG Grouper/Pricer calculates the payment at 100% rate for the first procedure and at 50% of the rate for the second procedure. • The capital add - on payment for ambulatory facility = $\$81.37$ • The total allowable amount per the fee schedule is $\$1,428.99$. Date of service 8/10/2018 (EOR dated 9/28/2018) amount billed = $\$1,350.00$: The provider billed CPT code 01992 AA P2. This is a physician charge. • Per the NJ fee schedule rules (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 section 50 - Payment for Anesthesiology Services (Rev. 3747; Issued: 04-14-17; Effective: 01-01-17; Implementation: 05-15-17) A. General Payment Rule The fee schedule amount for physician anesthesia services furnished is, with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor specific to that locality. • Per the Medicare guidelines: Actual anesthesia time in minutes is reported on the claim. For anesthesia services furnished on or after January 1, 1994, the A/B MAC computes time units by dividing reported anesthesia time by 15 minutes. Round the time unit to one decimal place. • Based on the documentation the submitted the total anesthesia time is 12 minutes (10:55 start time and 11:07 stop time.) divide by 15 = 0.8 • CPT code 01992 has base unit of 5 + .8 time units = (5.8 x 86.47 (CF Northern NJ) = \$501.53. • The allowable amount per the NJ fee schedule is \$501.53. NY Fee Schedule Calculation per the 33rd Amendment to Regulation 83: (noted above).

The provider billed CPT code 01992 AA P2 • As per the NY Workers' Compensation Medical Fee Schedule Anesthesia Ground rule 6: Calculation of Total Anesthesia Values: The total anesthesia value is calculated by adding the listed basic value and time units. The time units are computed by allowing one unit for each 15 minutes or fraction thereof, of anesthesia time. A fraction of time is defined as one minute. To calculate the fee expressed in dollars, multiply the total units by the anesthesia conversion factor for your region. Example: Total Units = Basic Value + Time Units x Dollar Conversion Factor = Total Dollar Amount. • Based on the documentation the submitted the total anesthesia time is 12 minutes (10:55 start time and 11:07 stop time) = 1 time unit. CPT code 01992 has a base unit of 5 + 1 time unit = 6 x \$27.01 (region IV CF) = \$162.06. Total allowable amount per the NY fee schedule.

Overall: For the facility: Per the NJ fee schedule (prevailing fee in the geographic location of the provider) the allowable amount = \$2,230.38. The total amount charged by the provider is \$2,586.34. The allowable amount per the NY fee schedule is \$1,428.99. As per the 33rd Amendment, the allowable amount \$1,428.99 (lowest amount). The provider was paid according to the fee schedule. For the physician: Per the NJ fee schedule (prevailing fee in the geographic location of the provider) the allowable amount = \$501.53. The total amount charge by the provider = \$1,350.00. The allowable amount per the NY fee schedule = \$162.06. As per the 33rd Amendment, the allowable amount = \$162.06(lowest amount). **The provider was paid according to the fee schedule."**

The decision in this case is based upon the oral arguments of the parties' representatives at the arbitration hearing and upon my review of the submissions as contained in the Electronic Case Folder maintained by the American Arbitration Association. I have reviewed the documents in MODRIA as of the date of the arbitration hearing, and incorporate and rely upon said documents in making my decision.

A health care provider-Applicant establishes its prima facie entitlement to No-Fault benefits by submitting proof that its claim was mailed to and received by the insurance carrier-Respondent, and that payment is overdue. *Viviane Etienne Med. Care, P.C. v. Country-Wide Ins. Co.*, 25 N.Y. 3d 498, 14 N.Y.S. 3d 283 (2015). Once Applicant has established a prima facie case, the burden shifts to the Respondent to present sufficient evidence to establish a lack of medical necessity for the services rendered. The insurer bears the burden of production. *Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 13 Misc. 3d 136A, 831 N.Y.S. 2d 351 (Table) (App. Term 1st Dept. 2006).

Although a defense based upon Fee Schedule for services rendered after 4/1/13 is now a non-precludable defense, it remains the burden of the Respondent to establish that the fees charged by a provider exceed the amounts set forth in the appropriate fee schedule. *Liberty Chiropractic, P.C. v. 21st Century Ins. Co.*, 53 Misc. 3d 133A, 2016 WL 5921834 (Table), 2016 NY Slip Op 51409(U) (App. Term 2d, 11th & 13th Jud. Dists. 2016), citing *Rogy Med, P.C. v. Mercury Cas. Co.*, 23 Misc. 3d 132A, 885 N.Y.S. 2d 713 (Table) (App. Term 2d, 11th & 13th Jud. Dists. 2009).

Applicant has established its prima facie case with proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law § 5106 a; *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]; *Amaze Med. Supply v. Eagle Ins. Co.*, 2 Misc. 3d 128A, 784 N.Y.S. 2d 918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]). The burden shifts to the insurer to prove that the services were not medically necessary.

Respondent argues that the fees charged by Applicant for the services in issue were in excess of those permitted under the Workers' Compensation Fee Schedule. 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 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). See also, *Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co.*, 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules 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 may interpose a defense in a timely denial that the claim exceeds the fees permitted by the Workers' Compensation schedules, but Respondent must, at minimum, establish, by evidentiary proof, that the charges exceeded that permitted by law. *Abraham v. Country-Wide Ins. Co.*, 3 Misc.3d 130A, 787 N.Y.S.2d 678, 2004 NY Slip Op 50388U, 2004 N.Y. Misc. LEXIS 544 (App. Term, 2d Dept. 2004). A brief from Respondent's counsel is not the substantive equivalent of "competent evidentiary proof." Furthermore, if an insurer contests and reduces a medical provider's fees for medical services rendered, then such reduction must be based upon a medical doctor's peer review or medical analysis of the services rendered vis-à-vis the fees charged and a medical explanation regarding why the charges are best described by another CPT billing code.

In the instant matter, the Respondent's coding adjustment was made based upon the fee audit prepared by Lisette Giffels, C.P.C., a professional fee coder. I find the fee analysis presented by Respondent's fee coder, Ms. Giffels, to be credible and persuasive.

It is therefore my determination that the Respondent's decision to down code and reimburse the Applicant the fee schedule allowable per the opinions and conclusions of Ms. Giffels was appropriate. Accordingly, the Respondent's denial is sustained, and the Applicant's claim for reimbursement in the amount of \$2,345.29 is hereby denied in its entirety. This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

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 claim is DENIED in its entirety

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

09/24/2020

(Dated)

Paul Weidenbaum

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:
eb99c658896e096fdcfc5d1421a0275

Electronically Signed

Your name: Paul Weidenbaum
Signed on: 09/24/2020