

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Surgicore Of Jersey City, LLC  
(Applicant)

- and -

Hereford Insurance Company  
(Respondent)

AAA Case No. 17-19-1136-1849

Applicant's File No. SS-117603

Insurer's Claim File No. 76599-02

NAIC No. 24309

**ARBITRATION AWARD**

I, Keith Tola, 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: EIP

1. Hearing(s) held on 11/02/2020  
Declared closed by the arbitrator on 11/02/2020

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

Tasnim Hassanali, Esq. from Law Offices of Rubin & Nazarian participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 2,944.90**, 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 case stems from a motor vehicle accident which occurred on July 8, 2018, wherein the EIP allegedly sustained injuries. Applicant seeks compensation of its facility fee associated with the left shoulder arthroscopic surgery performed on September 20, 2018. Respondent issued partial payment and defended based on fee schedule. The issue presented is whether respondent substantiated its fee schedule defense or whether applicant is entitled to additional compensation.

4. Findings, Conclusions, and Basis Therefor

This case was decided after due consideration of the arguments of the parties and after a review of the submissions and the documents contained in the electronic case folder maintained by the American Arbitration Association, as of the date of this hearing.

### **FEE SCHEDULE**

Applicant billed a total of \$5971.14, with a breakdown as follows:

Arthroscopy/debridement - Code 29823 - \$3026.24;

Synovectomy - Code 29821 - \$1472.45; and

Bursectomy - Code 29999 - \$ 1472.45.

Respondent issued payment in the amount of \$3026.24, representing 100% of the charge under Code 29823. As to Codes 29821 and 29999, the EOB indicates:

"This service is consolidated within another service which shares the same EAPG. There is no separate allowance made in this case.

At the hearing, the parties stipulated that EAPG Group 37 is applicable for rate of reimbursement. Also, parties agree that 29823 is the main procedure and is to be afforded 100% compensation. The issue is whether applicant is entitled to compensation under Codes 29821 and 29999, both in light of its use of Modifier 59.

No party to this action has provided any expert opinion evidence from a Certified Professional Coder or the like. At the hearing, respondent relied on its explanation in the EOB, together with prior Arbitration Awards that addressed these billing issues. Applicant also relied on prior Awards in its favor, together with a copy of a print-out of the EAPG rate 37 calculation from its use of the 3m Core Grouping software. Simply put, applicant entered all codes and the appended Modifier 59 to Codes 26821 and 29999, and the software "spit out" a calculation that allowed for reimbursement of all codes billed, as billed.

Having reviewed applicant's 3M print-out, it is clear the software allowed for payment under Codes 29821 and 29999 solely on account of the fact that applicant inputted Modifier 59 to those codes. The issue presented, therefore, is whether Modifier 59 was appropriate, and that issue was not discussed at the hearing in any artful, meaningful way. As such, this Arbitrator has poured over numerous Awards issued by other Arbitrators who have dealt with this issue, and I find myself most aligned with AAA Case No.: 17-19-1136-1870 (10/30/20), wherein Arbitrator Saxon indicated, in relevant part:

"

"... I am persuaded by Arbitrator Chow's analysis of the issue in New Horizon Surgical Center LLCv. Maya Assurance Company, AAA: 17-19-1131-1478 (8/21/20):

*In assessing this issue, I am persuaded by Respondent's expert coder's reasoned explanation regarding modifier 59 being inappropriate for these codes because they were all performed on the same shoulder. His position is supported by the Modifier 59 Article and the NCCI Policy Manuals.*

*I find the NCCI Policy Manual issued by the Centers for Medicare & Medicaid services (CMS) to be instructive in evaluating this issue. This manual provides guidance on how NCCI edits are to be used, and when it would be appropriate to suppress the NCCI edits. With the 3M software using NCCI edits developed by CMS, I find no reason why it would be improper to use the CMS issued NCCI Policy Manual as guidance to determine when modifier 59 would be appropriate to suppress the NCCI edits. Proof that the 3M software uses NCCI edits to render its calculation can be found in [1] the Workers' Compensation Enhanced Ambulatory Patient Group (EAPG) - Ambulatory Surgery Fee Schedule FAQs - Question 7, [2] the November 2015 3M presentation on New York Implementation (3M Enhanced Ambulatory Patient Groupings) and [3] TM Applicant's 3M worksheet itself under the "Edits" section in its analysis for CPT 29823, 29821, 29825 and 29826. Copies of the NCCI Policy Manuals are publicly available at the CMS official website located at <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Manual>*

*In this case, the Modifier 59 Article and the 2018 NCCI Policy Manual support Respondent's contention that modifier 59 was inappropriate since all procedures were performed on the same shoulder. 2018 NCCI Policy Manual, Chapter IV, Section E (Arthroscopy), Subsection #4 states the following:*

*"CMS considers the shoulder to be a single anatomic structure. With three exceptions an NCCI procedure to procedure edit code pair consisting of two codes describing two shoulder arthroscopy procedures shall not be bypassed with an NCCI-associated modifier when the two procedures are performed on the ipsilateral shoulder. This type of edit may be bypassed with an NCCI-associated modifier only if the two procedures are performed on contralateral shoulders. The three exceptions are described in Chapter IV, Section E (Arthroscopy), Subsection #7." (emphasis added).*

*The three exceptions listed on Chapter IV, Section E (Arthroscopy), Subsection #7 are as follows:*

*"CPT codes 29824 (arthroscopic claviclectomy including distal articular surface), 29827 (arthroscopic rotator cuff repair), and 29828 (biceps tenodesis) may be reported separately with CPT code 29823 if the extensive debridement is performed in a different area of the same shoulder."*

*In this case, the parties agreed that CPT 29827 and 29823 are reimbursable. This agreement is congruent with the exceptions listed in subsection #7. However, the use of modifier 59 for CPT 29821, 29825, 29826 and 29999 are*

*not listed as an exception and are all performed on the same ipsilateral shoulder, to wit: the left shoulder. As such, Respondent was correct in determining the use of modifier 59 for these codes to be inappropriate.*

Similarly, here modifier 59 for CPT 29821 are not listed as exceptions. This further supports Ms. Brown's analysis.

Arbitrator Chow goes on to state that:

*Furthermore, although these codes have different descriptions, it does not equate to them being considered a "different procedure or surgery" to warrant modifier 59. As per 2018 NCCI Policy Manual, Chapter I, Section E (Modifiers and Modifier Indicators), Subsection (1)(d), modifier 59 is appropriate for "different procedures/surgeries" when they are performed at separate anatomic sites, or at separate patient encounters on the same date of service. It is not appropriate if the different procedures were performed on the same anatomic site and same patient encounter. In this case, the alleged different procedures were all performed on the same shoulder during the same patient encounter rendering modifier 59 inappropriate. This analysis is congruent with the analyses by IHCs regarding the same issue found in the following awards: Arbitrator Ann Lorraine Russo, Surgicore Surgical Center LLC v. State Farm, AAA#: 17-19-1116-2108 (4/22/2020), Arbitrator Victor Moritz, Fifth Avenue Surgery Center LLC v. Allstate, AAA#: 17-18-1113-9435 (3/23/2020), and Arbitrator Ann Lorraine Russo, Fifth Avenue Surgery Center LLC v. National General Insurance Online, Inc., AAA#: 17-18-1091-0535 (8/30/2019).*

I also find a recent decision by Arbitrator Mir on the issue persuasive. In Surgicore Of Jersey City, LLC v. Geico Insurance Company (17-19-1150-2574, 10/25/20), Arbitrator Mir also consulted an IHC and found as follows:

*Lastly, I requested an Independent Healthcare Consultant (IHC) report to review and evaluate the fee schedule issue. Joyce Ehrlich, a Certified Professional Medical Auditor issued an opinion after reviewing the claim, operating report and medical record, both fee coder affidavits, and the fee schedule. Ms. Ehrlich stated that "I arrived at the EAPG amount using the DOH rate files available to perform this function manually." She noted that "the EAPG computation may be performed manually and the 3M product is not absolutely required to make the necessary calculations." Regarding modifier 59, she stated,*

*"justifying the use of modifier 59 based [on] separate incisions which are inherent to the procedure during the same operative session, on the same site, and not considered a distinct or independent procedure, is incorrectly interpreting the AMA CPT manual definition of modifier 59."*

*She stated that the AMA CPT manual defines modifier 59 as follows, "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."*

*She stated that the use of modifier 59 in the case of arthroscopic surgery is incorrect unless certain circumstances exist which must be documented in the medical record. She noted that from an NCCI perspective, "the definition of different anatomic sites includes different organs, or in certain instances different lesions in the same organ . . . however, NCCI edits are typically created to prevent the inappropriate billing of lesions and sites that should not be considered to be separate and distinct," She stated that modifier 59 "should only be used to identify clearly independent services that represent significant departures from the usual situations described by the NCCI edit, and "the treatment of contiguous structures in the same organ or anatomic region does not constitute treatment of different anatomic sites." She noted that arthroscopic treatment of structures in adjoining areas of the same shoulder constitutes treatment of a single anatomic site.*

*Regarding Ms. Prajapati's statement regarding the use of Modifier 59, she stated that, "since the shoulder is composed of three compartments, it would not be medically feasible to perform the arthroscopy properly without creating multiple incisions to gain access." She noted that the "incisions were made to complete procedures which are not reimbursed separately." She also noted that the 3M Software interprets what has been entered into the system and does not have the ability to review the operative report, know where the incisions were made, or whether the documentation supports modifier 59. She stated that, "applying NCCI edits and CPT guidance in this case, provides more accurate guidance." She also stated that Ms. Prajapati was incorrect to state that EAPG group 37 is not subject to consolidation. She stated that Ms. Prajapati referred to EAPG "types", not EAPG groups, and she failed to correctly interpret the FAQs she cited. Finally, she noted that "if the physician performs both procedures on the right shoulder and bills the procedures together they are considered bundled services and as such only CPT 29823 will be reimbursed. Similarly to the Respondent's fee coder, she noted that based on the documentation, CPT code 29821, 29825, and 29819 would not be separately reimbursed. She agreed with Respondent that the total reimbursement for CPT 29823 should be \$3026.24."*

Similar to the cases above, Applicant's arthroscopic procedures were performed on the same anatomic site and same patient encounter. I find that modifier 59 was incorrectly applied Respondent has sufficiently established its defense that these claims were billed in excess of the applicable fee schedule. Applicant fails to sufficiently and persuasively refute Respondent's rationale. As such, Applicant's claim for reimbursement under Codes 29821 and 29999 is denied.

Since respondent already paid the required \$3026.24 under Code 29823, applicant is not entitled to any additional compensation and this claim is hereby denied.

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
	<b>Surgicore Of Jersey City, LLC</b>	<b>09/20/18 - 09/20/18</b>	<b>\$2,944.90</b>	<b>Denied</b>
<b>Total</b>			<b>\$2,944.90</b>	<b>Awarded: \$0.00</b>

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

12/02/2020  
(Dated)

Keith Tola

### **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:**  
89f82426318d5504ab132bdeb98815e0

### **Electronically Signed**

Your name: Keith Tola  
Signed on: 12/02/2020