

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

All City Family Healthcare Center
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-19-1143-2171
Applicant's File No.	BT19-104109
Insurer's Claim File No.	0503309180101047
NAIC No.	35882

ARBITRATION AWARD

I, Eileen Hennessy, 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-D.V.M.

1. Hearing(s) held on 07/22/2020
Declared closed by the arbitrator on 11/16/2020

Jason Behar from The Tadchiev Law Firm, P.C. participated by telephone for the
Applicant

Jesse Bush from Geico Insurance Company participated by telephone for the
Respondent

2. The amount claimed in the Arbitration Request, **\$ 8,765.33**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated and agreed that (i) Applicant has met its prima facie burden by submitting evidence that payment of no-fault benefits is overdue, and proof of its claims were mailed to and received by Respondent and (ii) Respondent's denials of the subject claims were timely issued.

3. Summary of Issues in Dispute

The record reveals that the Assignor-D.V.M., a 30-year-old male, claimed injuries as the driver of a motor vehicle involved in an accident which occurred on 3/8/2019. Applicant seeks reimbursement for the facility fee for a right shoulder arthroscopic surgery and brachial plexus nerve block injection under ultrasonic guidance conducted on 6/14/2019.

Respondent denied the bills based on the peer review of Julio Westerband, M.D., dated 7/31/2019. The issues to be determined are 1) whether the services were medically necessary and, if so, 2) whether the services were billed in accordance with the applicable fee schedule?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement for the facility fee for a right shoulder arthroscopic surgery and a brachial plexus nerve block injection under ultrasonic guidance. This hearing was conducted using the documents contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association. All documents contained in the ECF are made part of the record of this hearing and my decision was made after a review of all relevant documents found in the ECF as well as the arguments presented by the parties during the hearing.

An arbitrator shall be the judge of the relevance and materiality of the evidence and strict conformity of the legal rules of evidence shall not be necessary in accordance with 11 NYCRR 65-4.5(o) (1). Further, the arbitrator may question or examine any witnesses and independently raise any issue that Arbitrator deems relevant to making an award that is consistent with the Insurance Law and the Department Regulations.

Legal Standards for Determining Medical Necessity

To support a lack of medical necessity defense, Respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." *See Provvedere, Inc. v. Republic Western Ins. Co.*, 2014 NY Slip Op 50219(U) (App. Term 2nd, 11th and 13th Jud. Dists. 2014). Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to applicant. *See generally, Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006). The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, *Kingsbrook Jewish Medical Center v. Allstate Ins. Co.*, 61 A.D.3d 13, 871 N.Y.S.2d 680 (2d Dept. 2009), such as by a qualified expert performing an independent medical examination or conducting a peer review of the injured person's treatment. *See Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp.*, 2003 N.Y. Slip Op. 50842(U), 2003 WL 21049583 (App. Term 2d & 11th Dists. Apr. 1, 2003). The appellate courts have not clearly defined what satisfies the insurer's evidentiary standard except to the extent that "bald assertions" are insufficient. *Amherst Medical Supply, LLC v. A Central Ins. Co.*, 41 Misc.3d 133(A), 981 N.Y.S.2d 633 (Table), 2013 NY Slip Op 51800(U), 2013 WL 5861523 (App. Term 1st Dept. Oct. 30, 2013). However, there are myriad civil court decisions tackling the issue of what constitutes a "factual basis and medical rationale" sufficient to establish a lack of medical necessity. The trial courts have held that a peer review report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical

rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. *See generally Nir v. Allstate Ins. Co.*, 7 Misc.3d 544, 547, 796 N.Y.S.2d 857, 860 (Civ. Ct. Kings Co. 2005); *See also, All Boro Psychological Servs. P.C. v. GEICO*, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012).

Where a Respondent meets its burden, it becomes incumbent on the claimant to rebut the peer review. *Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co.*, 18 Misc.3d 139(A), 2008 WL 506180 (App. Term 2d & 11 Dists. Feb. 21, 2008); *A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co.*, 16 Misc.3d 131(A), 2007 WL 1989432 (App. Term 2d & 11 Dists July 3, 2007. "[T]he insured/provider bears the burden of persuasion on the question of medical necessity. Specifically, once the insurer makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity, 'plaintiff must rebut it or succumb.'" *Bedford Park Medical Practice, P.C. v. American Transit Ins. Co.*, 8 Misc.3d 1025(A), 2005 WL 1936346 at 3 (Civ. Ct. Kings Co., Jack M. Battaglia, J., Aug. 12, 2005). "Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity (*see* Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11 ed])." *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.*, 13 Misc.3d 131(A), 2006 N.Y. Slip. Op. 5187(U) at 2, 2006 WL 2829826 (App. Term 2d & 11 Dists. Sept. 29, 2006).

Application of Legal Standards

Right shoulder arthroscopic surgery and a brachial plexus nerve block injection under ultrasonic guidance were conducted on 6/14/2019. In support of its contention that the services were not medically necessary, Respondent relies upon the peer review of Julio Westerband, M.D., dated 7/31/2019. Applicant relies on the rebuttal of treating physician Howard Baum, M.D., dated 5/26/2020.

I find Dr. Westerband's peer review to be sufficient for the purpose of establishing the defense of lack of medical necessity. Dr. Westerband adequately sets forth the factual basis and medical rationale to support his conclusion that the right shoulder arthroscopic surgery and brachial plexus nerve block injection under ultrasonic guidance were not indicated for the Assignor. That being so, the burden shifts to the Applicant to counter Respondent's showing.

I am faced with conflicting opinions concerning the medical necessity for the disputed surgery herein. There are no legal issues to resolve. This dispute involves solely an issue of fact, that is, whether the surgery and related services, including the facility fee in dispute, were medically necessary. Resolution of that fact is determined by which opinion is accepted by the trier of fact.

Having carefully reviewed the evidence, including the rebuttal statement, dated 5/26/2020, the examination reports by Howard Baum, M.D., dated 4/1/2019 and 6/3/2019, and Shouhei Yamagami, M.D., dated 3/12/2019 and 4/9/2019, the CAT Scan of the right shoulder, dated 3/14/2019, physical therapy records, dated 3/2/2019 through

7/3/2019, and the operative report, dated 6/14/2019, I find, as a matter of fact, that the right shoulder arthroscopic surgery and brachial plexus nerve block injection under ultrasonic guidance were medically necessary. The rebuttal and examination reports set forth clinical findings and explain the significance of those findings in relation to the right shoulder arthroscopic surgery and brachial plexus nerve block injection under ultrasonic guidance that were performed. I find the reports and rebuttal sufficiently address the arguments that were raised in the peer review. Having carefully considered the entire record, I find that the more credible and persuasive proof resides with the Applicant.

Accordingly, Applicant's claim is granted and the issue to be determined is the appropriate reimbursement.

FEE SCHEDULE

Payment of No-Fault claims are governed by N.Y. Ins. Law § 5106 (McKinney 1999-2000). Section 5106 (a) provides, in pertinent part:

Payments of first party benefits and additional first party benefits shall be made as the loss is incurred. Such benefits are overdue if not paid within thirty days after the claimant supplies proof of the fact and amount of loss sustained. If proof is not supplied as to the entire claim, the amount which is supported by proof is overdue if not paid within thirty days after such proof is supplied.

To establish a prima facie showing of its entitlement to reimbursement, as a matter of law, Applicant must submit evidentiary proof that the prescribed statutory billing forms, setting forth the facts and the amount of the loss sustained, were mailed and received and that payment of no-fault benefits is overdue. *See Mary Immaculate Hospital v. Allstate Ins. Co.*, 5 A.D.3d 742 (2004).

It is well established that a healthcare provider must limit its charges according to the applicable fee schedule. *Goldberg v. Corcoran*, 153 AD2d 113, 117-18 (App Div, 2d Dept 1989). Amended Regulations section 65-3.8(g)(1) states proof of the fact, and amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances: (i) when the claimed medical services were not provided to an injured party; or (ii) for those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers. This subdivision applies to medical services rendered on or after April 1, 2013.

It is respondent's burden to come forward with competent evidentiary proof to support its fee schedule defenses. *See Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co.*, 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 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 N.Y. Misc. LEXIS 1109 (App. Term, 1 Dep't, per curiam, 2006). A 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 N.Y. Misc. LEXIS 544 (App. Term, 2d Dept. 2004).

An insurer's unilateral decision to re-code or change a medical provider's billed CPT codes, to reimburse disputed medical services at a reduced rate, or to deny a claim in its entirety, is ineffectual when unsupported by a peer review report or by other proof setting forth a sufficiently detailed factual basis and medical rationale for the code changes, fee reductions and denials. *See Amaze Medical Supply v. Eagle Insurance Company*, 2 Misc 3d 128A (App Term 2d and 11th Jud Dist 2003). A lay person is not qualified to evaluate the CPT codes or to change if the code is used by a health provider in its bills. *See Abraham v. Country-Wide Ins. Co.*, 3 Misc. 3d. 130A (App. Term 2d. Dept. 2004). Once the insurer makes a prima facie showing that the amounts charged by a provider were in excess of the fee schedule, the burden shifts to the provider to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. *Cornell Medical, P.C. v. Mercury Casualty Co.*, 24 Misc. 3d 58, 884 N.Y.S.3d 558 (App. Term 2d, 11th & 13th Dists. 2009).

ANALYSIS

Applicant's bill sought \$8,765.33 for the Ambulatory Surgical Center (ASC) facility fee for right shoulder arthroscopic surgery and brachial plexus nerve block injection under ultrasonic guidance conducted on 6/14/2019. Applicant billed the ASC fee for the right shoulder surgery under CPT codes 29825 (\$3,026.24), 29822 59, 29821 59, and 29826 59 (\$1,472.45 each). For the brachial plexus nerve block injection under ultrasonic guidance, Applicant billed \$1,327.74 under codes 64415 (\$979.78) and 76942 (\$341.96).

Judicial notice of the New York Fee Schedule is taken. *See, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co.*, 61 A.D.3d 13, 20 (2d Dept. 2009); *LVOV Acupuncture, P.C. v. Geico Ins. Co.*, 32 Misc.3d 144(A) (App Term 2d, 11th & 13th Jud Dists. 2011); *Natural Acupuncture Health, P.C. v. Praetorian Ins. Co.*, 30 Misc.3d 132(A) (App Term, 1st Dept. 2011).

The New York Worker's Compensation Fee Schedule is applicable to the services billed. Effective 10/11/15, the New York State Workers Compensation Board adopted the EAPG Methodology for Calculating Ambulatory Surgery Fee Schedules, replacing the prior Products of Ambulatory Surgery (NYPAS) methodology. Under the EAPG payment methodology, reimbursement is related to the actual services provided based on patient diagnosis and the CPT/HCPCS codes reported on the claim. The CPT/HCPCS codes are grouped into APG code groups according to the procedure and/or diagnosis. Each APG has an average weight based on the group's average cost. That figure is multiplied once by 100%. Each code is then multiplied by an established base rate by

setting. The primary code is increased by a "capital add - on" and the numerical value for each code is added together.

In support of its calculation, Respondent has submitted the affidavit of Kathryn Moran, Certified Professional Coder (CPC). Ms. Moran indicates that Applicant is entitled to \$3,556.82 for the ASC fee for the surgery and injection. Specifically, Ms. Moran indicates that Applicant is entitled to reimbursement for CPT code 29825 (\$2,944.87 plus \$81.37 for the capital add on = \$3,026.24) with the remaining codes 29822 59, 29821 59, and 29826 59 not reimbursable. As to the nerve block injection, Ms. Moran indicates that Applicant is entitled to \$530.58 for code 64415 (\$449.21 + \$81.37 for the capital add on) while code 76942 is not reimbursable.

The parties agree that if the services are found to be medically necessary, code 29825 is the significant procedure code for the right shoulder surgery and is reimbursable at \$2,944.87 plus the capital add on of \$81.37 for a total of \$3,026.24, leaving codes 29822 59, 29821 59, 29826 59, 64415 and 76942 59 in dispute.

Ms. Moran notes that "CPT codes 29821, 29822 and 29826 are consolidated as per EAPG Guidelines. CPT codes 29821, 29822 & 29826 have an APG assignment of 37. APG 37 includes APG 37 as they are inclusive. Furthermore, based on the NCCI Policy Manual for Medicare Services CPT codes 29821 and 29822 should not be reported along with the procedure CPT code 29825. CPT codes 29821 and 29822 have a PTP Edit Rationale of: Standards of medical/surgical practice".

Ms. Moran notes that "The provider incorrectly appended modifier 59 on CPT code 29822, 29821 and 29826 to go around the EAPG Guidelines 'Significant Procedure Consolidation' Appendix E APG Consolidation in order to be reimbursed. As per EAPG Guidelines, Edits applied as defined by CMS for Medicaid Use: National Correct Coding Initiative (NCCI) Edits are utilized for correct coding and reimbursement practices. NCCI Policy Manual for Medicare Services (www.cms.gov)".

Per Modifier 59 Article, Assignee's use of modifier 59 with CPT 29822, 29821 and 29826 is improper as the services were performed in the same anatomic site (right shoulder). Per the above instructions, Assignee's use of modifier 59 fail to bypass the above coding edits. Assignee has not bypassed the above coding edits and may not report CPT 29822, 29821 and 29826 together with CPT 29825. As CPT codes 29822, 29821 and 29826 may not be reported, they cannot be billed. Therefore, Assignee is not entitled to any reimbursement for CPT codes 29822, 29821 and 29826.

Ms. Moran's EAPG analysis further indicates that code 64415 is reimbursable at \$449.21 before the capital add on for a total of \$530.58. "As per EAPG Guidelines on Discounting: Multiple unconsolidated significant procedure EAPGs' The highest weighted EAPG is paid at 100% and the EAPGs' with lesser weighted amount that are not consolidated are paid at 50%. The significant procedure billed by the same provider on the same day is CPT 29825 (stated as CPT code 29822 in error) displayed in Bill 1. CPT code 64415 is discounted at 50% as this is a multiple unconsolidated procedure and will be discounted based on the EAPG guidelines". Ms. Moran further notes: "CPT code 76942 per the EAPG CPT Crosswalk is APG 472. 76942 is considered ancillary-

'ancillary is packaged to medical, significant procedure or therapy visit.' APG 472 is seen as inclusive to CPT code 29825 (stated as CPT code 29822 in error) performed on same day. Therefore, the reimbursement is \$0.00".

Applicant indicates it is entitled to the billed amount of \$8,765.33. Applicant has submitted an Affirmation by Alpa Prajapati, CPC. Mr. Prajapati indicates that the following is due for the surgery: 29825 (\$3,026.24), 29822, 29821 and 29826 (\$1,472.45 each) and the following is due for the injection: 64415 (979.78) and 76942 (\$341.96). Applicant relies on Modifier 59 and Ground Rule 5 of the New York State Workers Compensation fee schedule, Surgery, which reads: "when multiple procedures, unrelated to the major procedure and adding significant time and complexity are provided at the same operative session, payment is for the procedure with the highest allowance plus half of the lesser procedures. The same rule applies for bilateral procedures when such are not specifically identified in schedule. It is appropriate to designate multiple procedures that are rendered on the same date by separate entries. This can be reported by using the multiple procedure modifier 51" in support of its position.

Applicant argues that as the services were performed in an ASC rather than hospital-based surgery center that only the NCCI edits for hospital outpatients may be utilized according to the New York Worker's Compensation Board (NYWCB) and the EAPG Implementation Guide. Applicant argues that hospital outpatients and freestanding ASCs are covered under separate NCCI edits according to CMS.gov and Medicaid and the NYWCB has not indicated that the ASC NCCI edits should be utilized under the EAPG methodology. Therefore, Ms. Moran's reliance on the NCCI edits was misplaced. Mr. Prajapati argues that Applicant did not need to rely on Modifier 59 to bypass the NCCI edits for ASCs as they are not applicable in this matter. Regardless, Modifier 59 was properly utilized according to the CPT Manual as there were separate incisions in the posterior and lateral portions of the glenohumeral joint as indicated in the operative report.

As to codes 64415 and 76942, Mr. Prajapati indicates these services were billed separately as a different physician conducted the injection than conducted the right shoulder surgery. Therefore, consolidation of the codes is not appropriate. He notes that Applicant utilized the 3M APG Grouper software, as indicated by the 3M calculation sheet submitted to the record, to calculate the appropriate reimbursement. This is the recommended program to conduct EAPG analysis as indicated by the NYS Workers' Compensation Board and the APG Manual and the calculations are therefore correct.

I believed it appropriate to forward this dispute to an IHC made available to arbitrators for multiple issues pursuant to 11 NYCRR 65-4.7(a), including fee schedule analysis. *See Fifth Avenue Surgery Center LLC and Allstate Fire & Casualty Insurance Company*, AAA Assessment No.: 99-18-1098-3143, [Master Arbitrator Joseph J. O'Brien, Jr., 6/25/2020].

I acknowledge I received a report from the IHC consultant, Ms. Julia Nabiullina, CPC, CPCO, CPMA, CRC, a Certified Professional Medical Auditor and Compliance Officer, credentialed by the American Academy of Professional Coders ("AAPC") with six

years' experience in medical auditing, which indicated that the maximum reimbursement for the services billed is \$3,556.82. Specifically, she noted my request in terms of what the proper rate of reimbursement will be for the service billed, utilizing the information provided to the IHC, along with multiple records which were noted. She noted that she conducted the EAPG calculations manually in accordance with the NYS Worker's Compensation Fee Schedule and the appropriate guidelines, which she listed, including, but not limited to, the 3M™ Enhanced Ambulatory Patient Groups (EAPGs) presentation.

Ms. Nabiullina noted "Our consulting firm was asked to review provided documents and advise which services are reimbursable to the Applicant [ASC], the appropriate rate for any service determined reimbursable and provide an explanation for any service deemed as non-reimbursable".

Ms. Nabiullina provided EAPG mathematical analysis charts and indicated codes 29825 (\$3,026.24) and 64415 (\$530.58) were allowed for a total of \$3,556.82 with the remaining codes disallowed. She provided her analysis, in the report, dated 8/21/2020 and updated 10/8/2020, which stated, in pertinent part:

In reviewing supporting documentation, including Exhibit C for Medical Records, the following questions were addressed:

1. 29825-RT Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation- Right Side. **ALLOWED**

Conclusion: It appears that parties, including our firm, agree with coding, documentation and rate calculation for this item, while using different approved methodologies. Our firm has performed manual calculations using appropriate guideline.

2. 29822-RT-59 Arthroscopy, shoulder, surgical; debridement, limited.

DISALLOWED.

Problem Statement: parties disagree on coding and billing for debridement of the 5% biceps tendon during procedure. It appears that while GEICO coder mentioned CPT code 29822 to be consolidated as per EAPG Guidelines having an APG assignment of 37, as well as referenced American Academy of Orthopaedic Surgeons and NCCI Policy Manual for exclusion. ASC coder believes that the reference provided by AAOS should not be considered for consolidation and disagrees with NCCI Policy to be applicable for ASC.

Conclusion: Our firm confirms that a) 29822 is indeed consolidated per EAPG guidelines and should not be reimbursed separately b) according to

C M S . g o v (<https://www.cms.gov/ResearchStatistics-Data-and-Systems/Monitoring-Program>), when performed with another arthroscopic shoulder procedure on the same shoulder, the debridement is bundled into the primary surgical code(s). Same rule is supported by NCCI edits. See Rationale 8 for more details clarifying that NCCI Policy does apply to ASCs.

3. 29821-RT-59 Arthroscopy, shoulder, surgical; synovectomy, complete.

DISALLOWED

Problem Statement: parties disagree on coding and billing for synovectomy procedure. It appears that while GEICO coder mentioned CPT code 29821 to be consolidated as per EAPG Guidelines having an APG assignment of 37, as well as referenced American Academy of Orthopaedic Surgeons and NCCI Policy Manual for exclusion. ASC coder believes that the reference provided by AAOS should not be considered for consolidation and disagrees with NCCI Policy to be applicable for ASC.

Conclusion: Upon further review of the Operative Note in Exhibit C, our firm noted that, based on Doctor's documentation, synovectomy procedure has not been documented (hence, not performed) and, therefore, should not be billed. The American Medical Association (AMA) and the American Academy of Orthopaedic Surgeons (AAOS) agree that, in order to report 29821, the "entire intra-articular synovium" must be removed (CPT® Assistant, June 2013, and AAOS Bulletin, April 2006). However, based on the medical chart, the Doctor has NOT removed, rather resected synovitis and anterior adhesions.

4. 29826-RT-59 Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e, arch) release, when performed (List separately in addition to code for primary procedure) **DISALLOWED**

Problem Statement: parties disagree on coding and billing for synovectomy procedure. It appears that while GEICO coder mentioned CPT code 29821 to be consolidated as per EAPG Guidelines having an APG assignment of 37, as well as referenced American Academy of Orthopaedic Surgeons and NCCI Policy Manual for exclusion. ASC coder believes that the reference provided by AAOS should not be considered for consolidation and disagrees with NCCI Policy to be applicable for ASC.

Conclusion: Upon further review of the Operative Note our firm noted that partial acromioplasty procedure was not documented/performed and, therefore, should NOT be billed. In order to support CPT code 29826, bone (acromion) removal is required to be clearly documented. Normally, discussion about the morphology (specifically type I, II, or III) is included in the operative notes. This determines if the acromion is flat, curved, or hooked. However, based on the medical chart provided, doctor documents that "subacromial adhesions were resected and soft tissue acromioplasty was completed...There was no bone needed to be removed" which qualifies for debridement but NOT partial acromioplasty.

5. 64415-RT Injection, anesthetic agent; brachial plexus, single- Right Side.

ALLOWED

Problem Statement: It appears that parties, including our firm, agree with coding and documentation of this procedure. However, coders disagreed on rate calculation for this item. While ASC coder believes it should be reimbursed at 100%, the GEICO coder objects advising 50% of reimbursement.

Conclusion: According to EAPG Guideline "Significant Procedures: Consolidation and Discounting", multiple significant procedures on same day fall under discounted price. The highest weighted EAPG (29825-RT) should be paid at 100% and the EAPGs' with lesser weighted amount (64415-RT) that is not consolidated should be paid at 50%.

6. 76942-59-TC Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation **DISALLOWED**

Problem Statement: parties disagree on coding and billing for imaging, Technical Component.

Conclusion: The nature of the main procedure "Arthroscopy" is insertion of a small camera, called an arthroscope, into the shoulder joint. The camera displays pictures on a video monitor, so the surgeon could use these images to guide miniature surgical instruments. According to Medicare NCCI 2019 Coding Policy Manual, Section H.8, "guidance for a needle placement procedure by the same radiologic modality on the same date of service may be reported separately if the two procedures are performed in different anatomic regions". Based on Operative Note provided, this statement is not applicable to the case. Therefore, CPT code 76942 is inclusive to CPT code 29825.

7. Modifier 59 According to CPT Manual, "Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. **DISALLOWED**

Problem Statement: parties disagree on use of Modifier 59 to unbundle consolidated services. Both parties use the same statement but emphasize different parts of it.

Conclusion: The Centers for Medicare & Medicaid Services (CMS) and the American Academy of Orthopaedic Surgeons (AAOS) have opposing views on shoulder anatomy. AAOS recognizes the glenohumeral joint, the acromioclavicular (AC) joint, and the subacromial bursa as separate anatomic areas. CMS, by contrast, considers the shoulder to be a single anatomic region. According to CMS, modifier 59 can be used only if the second procedure was performed on the opposite side of the shoulder, which in this case is the same Right side and is NOT appropriate to bypass the bundling edit. For more information about opposing views between CMS and AAOS, please reference to the Advocacy Article of The Arthroscopy Association of North America in <https://www.aana.org/AANAIMIS/Members/Membership/Advocacy/Members/1>

8. NCCI Policy Manual reference **ALLOWED**

Problem Statement: parties disagree on referencing to NCCI Policy Manual for bundled services. ASC coder believes, that NCCI edits should not apply to ASCs and references to the material, that contradicts his own statement, indicating free-standing ASCs being impacted by the rules.

Conclusion: Under the National Correct Coding Initiative (NCCI) edits used by Medicare, Medicaid, workers' compensation payers, and some other commercial health payers, providers may never use an NCCI modifier, such as 59 Distinct procedural service, XE Separate encounter, XP Separate practitioner, XS Separate structure, or XU Unusual non-overlapping service to bypass the procedure-to-procedure edits in place for shoulder surgery, unless the service is performed on the opposite shoulder. NCCI is required for use by Medicaid per the Affordable Care Act, and it has been adopted by 20 states for workers' compensation, including New York and New Jersey.

Post-IHC

On receipt of this report, dated 8/21/2020, and forwarding to both parties, I note that both Applicant and Respondent were given time to respond, which neither party chose to do. Upon receipt and review of the IHC report, I submitted additional questions to Ms. Nabiullina for clarification. Ms. Nabiullina answered all questions posed in an updated IHC report, dated 10/8/2020. The analysis referenced above includes her updated response.

Both parties were given an opportunity to respond to Ms. Nabiullina's supplemental IHC report, dated 10/8/2020, which they chose not to do.

CONCLUSION

Judicial notice of the New York fee schedule is taken. In light of the expertise of Ms. Nabiullina, who provided a detailed analysis of the codes in dispute, I find it to be persuasive in terms of reimbursement. Notably Ms. Nabiullina agreed with the final reimbursement set forth by Ms. Moran.

I find the IHC's calculations, based on a clear reading of the operative report, New York fee schedule, the CPT Guidelines, and all applicable sources, sufficient to establish a prima facie showing that the amounts charged by Applicant were in excess of the fee schedule.

As noted by Independent Health Consultant (IHC) Joyce Ehrlich in an IHC report prepared for *Surgicore Surgical Center, LLC v. Nat'l General Ins. Co.*, AAA Case No.: 17-19-1121-0157 [Arbitrator Eileen Hennessy, 6/9/2020], which addressed the use of Modifier 59, and is relevant to the services billed:

The 3M Software is not run on artificial intelligence, meaning that it simply interprets what has been entered into the system and produces a payment schedule. The 3M HIS does not have the ability to review the

operative report and note whether or not the documentation supports the use of modifier -59, nor does it know where incisions were made or which compartments were repaired. It takes what is entered and calculates the reimbursement based on EAPG. It does not have the ability to analyze whether modifier -59 has been used solely to bypass the PTP code pair edit. Therefore, relying solely on a printout for the 3M System, disregards the medical documentation supporting the codes assigned to the claim. Applying NCCI edits and CPT guidance in this case, provides more accurate guidance for reimbursement for this claim.

Furthermore, according to the *National Correct Coding Initiative Policy Manual for Medicare Services*:

Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

The treatment of contiguous structures in the same organ or anatomic region does not constitute treatment of different anatomic sites. For example:

- Treatment of the nail, nail bed, and adjacent soft tissue distal to and including the skin overlying the distal interphalangeal joint on the same toe or finger constitutes treatment of a single anatomic site. (See example 4)*
- Treatment of posterior segment structures in the eye constitutes treatment of a single anatomic site. (See example 5)*
- Arthroscopic treatment of structures in adjoining areas of the same shoulder constitutes treatment of a single anatomic site. (See example 6)*

Example 6: Column 1 Code / Column 2 Code - 29827/29820

"CPT Code 29827 - Arthroscopy, shoulder, surgical; with rotator cuff repair and CPT Code 29820 - Arthroscopy, shoulder, surgical; synovectomy, partial

CPT code 29820 should not be reported and modifier 59 should not be used if both procedures are performed on the same shoulder during the same operative session because the shoulder joint is a single anatomic structure. If the procedures are performed on different shoulders, modifiers RT and LT should be used, not modifier 59.

Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, noncontiguous lesions in different anatomic regions of the same organ". Stating that the three separate incisions qualifies as three separate procedures, and therefore allows for the use of modifier -59 in a misinterpretation of the true purpose of modifier -59. 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 to diagnose and repair the injured areas. The surgeon needs to visualize the areas and the only way to do so is by creating multiple port holes for the insertion of instruments.

The burden now shifts to Applicant to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. See Cornell Medical, supra. Applicant has failed to meet the burden in rebuttal. I find that Respondent has met its burden and established by a preponderance of credible evidence its fee schedule defense. I find that Respondent's fee schedule reductions are consistent with the New York State Worker's Compensation fee schedule.

Therefore, Applicant is granted \$3,556.82 for codes 29825 (\$3,026.24) and 64415 (\$530.58) with the remaining codes denied.

CONCLUSION

Accordingly, Applicant's claim is granted in the amount of \$3,556.82. The remainder of the claim is denied. This award is in full disposition of all No-Fault benefit claims submitted to 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 applicant is AWARDED the following:

A.

Medical	From/To	Claim Amount	Status
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	All City Family Healthcare Center	06/14/19 - 06/14/19	\$7,443.59	Awarded: \$3,026.24
	All City Family Healthcare Center	06/14/19 - 06/14/19	\$1,321.74	Awarded: \$530.58
Total			\$8,765.33	Awarded: \$3,556.82

- B. The insurer shall also compute and pay the applicant interest set forth below. 09/26/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. *See generally*, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30-day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when 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 Insurance Department regulations." *See*, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009). Based on the regulations, interest shall accrue from the date the applicant requested arbitration in this matter. *See*, 11 NYCRR 65-3.9(c).

C. Attorney's Fees

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

Applicant is entitled to an attorney's fee pursuant to Insurance Law §5106(a). After calculating the sum total of the first-party (No-Fault) benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, subject to the following limitations: In the event the above filing date was prior to Feb. 4, 2015, the attorney's fee is subject to a minimum of \$60.00 and a maximum of \$850.00, per 11 NYCRR 65-4.6(e). In the event the above filing date was on or after Feb. 4, 2015, the attorney's fee is subject to a maximum of \$1,360.00, per 11 NYCRR 65-4.6(d). In the event the above filing date was on or after Feb. 4, 2015 and first-party (No-Fault) benefits are awarded to more than one Applicant herein, the attorney's fee shall be calculated separately for each Applicant, each Applicant's attorney fee being subject to the \$1,360.00 maximum.

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

12/16/2020
(Dated)

Eileen Hennessy

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:
f6a14c021f397c5ce9e298bb06006622

Electronically Signed

Your name: Eileen Hennessy
Signed on: 12/16/2020