

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Fifth Avenue Surgery Center LLC
(Applicant)

- and -

Progressive Casualty Insurance Company
(Respondent)

AAA Case No. 17-19-1148-3666

Applicant's File No. NA

Insurer's Claim File No. 19-5203545

NAIC No. 24260

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 02/11/2021
Declared closed by the arbitrator on 02/11/2021

Robin Grumet, Esq. from Jakubowitz Law Firm PC participated in person for the Applicant

Jean Schabhuttl from Progressive Casualty Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,171.26**, 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, CG, is a 48yo female who was injured in a motor vehicle accident on 1/12/19. CG suffered injuries which resulted in her seeking treatment. In dispute is the Applicant's facility claim regarding a nerve block injection with ultrasound guidance provided with a left shoulder arthroscopic surgery performed on 6/25/19 in the total amount of \$1,171.26. Respondent denied the claim pursuant to a fee schedule defense. Therefore, the issue to be determined 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.

Respondent denied the claim stating in its denial of claim:

The New York State Workers' Compensation Board adopted the 3M Enhanced Ambulatory Patient Groups (EAPG) software preference and Edits to use the Medicaid code set of the CMS National Correct Coding Initiative (NCCI) to facilitate payment. This line has been flagged by the (NCCI) Facility edit database with a superscript of 0, which indicates that Column 2 of a code pair that is not allowed by NCCI even if a modifier is present.

Pursuant to the NYS APG Manual, "Grouping Elements of the APG Payment System": multiple related significant procedure APG's are consolidated into a single APG for the purpose of determining payment. "CPT Modifier 59 should be used to designate instances when distinct and separate multiple services with the same APG are provided to the patient on a single date of service (eg. Separate encounters, different surgeries, different sites or organ systems, separate incisions)." The use of Modifier 59 is inappropriate in this instance. Documentation submitted supports consolidated into a single APG for reimbursement which has been paid accordingly.

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 submits the fee coder affidavit by Lori Curtin, CPC, dated 1/3/20, in which Ms. Curtin opines:

Applicant submitted two claims for medical services allegedly rendered on June 25, 2019. Once claim was for

shoulder arthroscopy the codes billed were 29823; 29821-59; and 29825-59. The provider respectively assigned values of \$3,026.24; \$1,472.45 and \$1,472.45 to the claimed services. The second claim was for a Nerve Block with Ultrasound Guidance in the same region and used CPT Codes 64415 and 76942-TC-59 the provider respectively assigned values of \$829.30 and \$341.96. Copies of the claims form and supporting documentation are attached as Exhibit "1".

... Review of the records submitted in support of the claim demonstrate the Applicant is only entitled to \$3,026.24.

The calculation for the maximum amount allowed under the EAPG Fee Schedule is the "APG Code Weight" multiplied by the "New York Workers Compensation Base Rate" which equals the subtotal. The Capital Add-On then gets added where appropriate in order to arrive at the total payment for the primary APG group. APG groups other than the primary APG group do not receive a Capital Add-On.

The APG Code weight is based on the APG Code and the CPT Code/procedure performed (as followed by Medicaid and the New York Department of Health).

The New York Workers' Compensation Base Rate is derived from 150% of Medicaid's hospital base rate. The NY WCB rate, as well as the Capital Add-On has two regions: upstate and downstate. For the upstate region, the NY WCB rate is \$228.62 and for downstate is \$295.94. For the upstate region, the Capital Add-On is \$109.90 for Ambulatory Surgery Centers and \$108.48 for Hospitals. For the downstate region the Capital Add-On is \$81.37 for Ambulatory Surgery Centers and \$115.70 for Hospitals.

The National Correct Coding Initiative Edits (NCCI Edits), adopted by the Medicare and Medicaid, limits the use of modifier-59 when applied in the context of Arthroscopy. Chapter IV, Surgery: Musculoskeletal System, CPT Codes 20000-29999. Section E(4) reads in part, "... 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 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". Copies of relevant sections of the NCCI General Rules and Guidelines are attached as Exhibit "5".

CPT codes 29821 and 29825 are not listed as qualified payable exceptions, therefore, modifier -59 is not appropriate.

As set forth in the implementation guide, "...Significant procedure consolidation refers to the collapsing of multiple related significant procedure APGs into a single APG for the purpose of determining payment...". Review of the EAPG schedules in the 3M APG Crosswalk database assigns CPT codes 29823, 29821 and 29825 to the APG Group 37. The application of the predetermined weight, discounts, rate, and capital add on result in CPT code 29823 being compensated in the amount of \$3,026.24. Attached at Exhibits "6" and "7" are copies of the relevant APG Groups from the 3M APG Crosswalk database and Manual Calculation Sheet.

Pursuant to the Policy and Billing Guidance Ambulatory Patient Groups Provider Manual, Section 3.5 use of Visit and Episode Rate Codes "Exhibit "8" ... All services and procedures provided to a patient with the same date of service and rate code... must be billed together on one claim. If two claims are submitted for the same patient with the same date of service and the same provider. only the first claim will result in payment. The second claim will be denied. If a patient returns to the clinic for multiple visits on the same date of service. All the procedures must be billed on one claim with the appropriate APG rate code... if the provider attempts to submit multiple APG claims for that rate code for the same recipient/same date of service, only one claim will be paid. All others will be denied as duplicative claims..." Application of the guidelines eliminates the claim for the Nerve Block with Ultra Sound Guidance; further NCCI Guidelines concerning CPT codes 60000-69999 note "... the physician shall not report CPT Codes 64400-64530 for anesthesia for a procedure." Here the major procedure is the Arthroscopy performed on the same date of service. Copies of the relevant section of the NCCI guidelines are attached as Exhibit "9".

Based on my review of the claim and the claim handling for the bills in dispute, the applicant is only entitled to \$3,026.24 and the remainder of the claim should be

dismissed as billed in excess of the Worker's Compensation Fee Schedule pursuant to 11 NYCRR 65-3.8 (g)(1)(ii) and 11 NYCRR 68.7.

Progressive previously issued a payment of \$3,026.24; it is their position no further payment is due.

Applicant responds with a fee coder affidavit by Roza Vinogradov, CPC, dated 1/14/21, in which Ms. Vinogradov opines:

... I also disagree regarding insurance unilaterally removing modifier 59. The NY Workers' Compensation Board FAQs state insurance companies should calculate the payment as submitted on the bills, thereby answering negatively on whether a 59 modifier can be unilaterally removed: "Can modifier 59 be removed from a bill? The bill should be calculated as submitted by the facility..." These FAQs note a payor may only contest legality or the mathematical valuation of the charges, and this insurance company is not contesting legality of the billing or arithmetic value, but completely removing codes and the modifier from the claim form(s). Because the NY Workers' Compensation Enhanced Ambulatory Patient Group (EAPG) Ambulatory Fee Schedule specifically permits the stakeholder Surgical Center to use the 3M software to compute charges and there is no disagreement the charges on the bill(s) relate to legitimate surgical procedures, this payor is in a weak position. This center followed instructions.

Plus, modifier 59 was correct. There were multiple portal sites and three different procedures permitting 29821, 29823 and 29825 to be correctly coded together pursuant to their AMA descriptions. The operative report listed 5 different procedures. There were multiple portals "made one anteriorly and one posteriorly." The report described synovectomy billed under 29821 throughout the joint which is complete: "There was inflamed synovial tissue throughout the joint." Hence, there was synovial excision in subacromial, glenohumeral and acromioclavicular compartments. The report also described 29823 glenohumeral debridement of the cuff and labrum. The procedures included 29825 lysis of adhesions in the subacromial space.

Thus, the independent and distinct procedures were performed in the different subacromial, glenohumeral and/or acromioclavicular joint compartments using multiple incisions. Therefore, modifier 59 was appropriate

pursuant to the August 2012 Policy and Billing Guidance Ambulatory Patient Groups Provider Manual from the State of New York Department of Health (Manual).

Specifically, the Manual permitted a 59 modifier for discounting where there are separate incisions, independent services and/or distinct procedures performed in different point compartments on the same day. (Note: EAPG is NYS Medicaid, not Medicare.) CPT books, the AAPC, and coding resources traditionally consider billing of additional procedures in different compartments of a joint to be distinct. On page 14, the Manual: "CPT Modifier 59 (Separate Procedures or Distinct Procedural Service): CPT Modifier 59 should be used to designate instances when distinct and separate multiple services with the same APG are provided to the patient on a single date of service (eg. separate encounters, different surgeries, different sites or organ systems, separate incision») Modifier 59 may also be used to report those procedures/ services considered a component of another procedure, when the service is carried out independently or, considered unrelated or distinct from the other procedures/services

provided at the same time Normally, when multiple procedures map to the same APG, the additional occurrences (beyond the first) will consolidate (i.e., no payment at the line level). However, when Modifier 59 is used, the additional same APG procedures will pay at 50% of the amount paid for the first procedure." 3M already applied the 50% reduction here.

In fact, under the same heading, 'Workers' Compensation Enhanced Ambulatory Patient Group (EAPG) Fee Schedules," the website of the Workers' Compensation Board also advised to "learn about the EAPG methodology" by seeing the 3M EAPG Presentation. The NY presentation discussed the proper use of modifiers on page 18, and specifically states modifier 59 "Turns off consolidation - allows separate payment."

The result is not different for the anesthesiologist services which clearly involve different procedure for separate injection by a different physician reported by the surgical center. Insurance is improperly treating the second sheet of paper submitted in the same package in the same "claim" as a separate bill under Section 3.5. The submissions shows usage of 2 sheets of paper to signify differences between the surgeon and anesthesiologist. The sheets of paper were sent in the same envelope and

received at the same time as shown by the submissions in the case.

The way the billing and documents were created and packaged were for organizational purposes. Therefore, the center (not surgeon) properly reported 64415. Moreover, 76942 is payable since it was not a stand alone. It attaches to the sheet of paper with 64415 and/or the sheet of paper with codes 29821, 29823-59 and 29825-59. Code 76942 has APG 472. It is not listed in the New York State Department of Health Uniform Packaged Ancillaries. Therefore, cost was not consolidated for this reason as well.

What is more, an independent CPC rejected a similar insurance position in All City Family Healthcare Center Inc. and Geico Ins. Co., AAA's Case No. 17-19-1149-3725.

There, the insurance CPC discussed consolidating codes for minimally invasive percutaneous discectomy with annuloplasty (codes 62287, 22526 and 22527) "billed were in EAPG Group 28" and argued "all codes correspond to APG Group 28 and only one code is reimbursable per group." Similar to those codes being 28, these codes are 37, 220 and 472. In that case, at insurance request, there was an independent report by Julia Nabiullina, CPC, CPCO, CPMA, CRC. CPC Nabiullina countered that position and explained based on "appropriate guideline" the "Significant procedure consolidation (consolidation) refers only to significant procedures, 3M EAPGs types 2, 21, 22, 23, 24 or 25 (as of 2017). She stated that EAPG type 28 is not applicable to significant consolidation rule." The same result would be warranted in this case.

Moreover, I reviewed other fee schedule audits for similar services with insurance companies. In the past, this insurance company has paid similar codes together. Other third party payors and insurances have done likewise. Liberty Mutual's audit agree that it is inappropriate to remove modifier 59 from the claim forms. Liberty Mutual uses the 3M software for the EAPG pricing, and only contested valuation. These audits confirm wide variations in adjustments from the insurance company and confirmed the appropriateness of this center's claim.

Respondent submits an addendum by Ms. Mallory in response to this rebuttal in which Ms. Mallory opines:

Progressive submitted an affidavit previously outlining their review of the billing in dispute; this document is a response to Roza Vinogradov, CPC, affidavit regarding the facility services rendered June 25, 2019.

8. The initial portion of CPC Vinogradov's affidavit outlines that Progressive is using the improper NCCI (Hospital) edits. Since, as CPC Vinogradov points out, the services were, in fact, provided in an Ambulatory Surgery Center, Progressive would be remiss to use 'Hospital' edits. However, given the fact that there are not separate NCCI manuals (guidelines) for each type of provider, and the ground rules/guidelines applied are for practitioners (physicians), ASCs, Hospitals, etc., Progressive's review is accurate.

9. There is also a reference in CPC Vinogradov's affidavit (#9) - to the American Physical Therapy Association; any information contained therein is irrelevant to this facility (ambulatory surgery) billing.

10. CPC Vinogradov indicates in paragraph (#12) - "The proper way to calculate the charges according to the NY Workers' Compensation Enhanced Ambulatory Patient Group (EAPG)..." is using the 3M Core Grouper Software. However, CPC Vinogradov, neglects to include the entire answer to the above, choosing, instead to take the information out of context. The entire answer to FAQ #8 that is referred to reads, "The 3M Core Grouper software can be used to calculate APR DRGs for inpatient bills and EAPGs for outpatient bills. It should be noted that the 3M product is not required to make the necessary calculations. Alternate products may be available and the calculations can be done manually as well." CPC Vinogradov's affidavit indicates the payor (Progressive) is in a weak position since the 3M software was not used - based on the information provided by NYS, manual calculations are very much acceptable.

11. CPC Vinogradov's affidavit indicates (#16) Progressive improperly 'removed' modifier -59 from the billing submitted by the provider referring to the FAQs outlined by Workers' Compensation.

12. The entire response to the question regarding the removal of modifier -59 reads, "The bill should be calculated as submitted by the facility. The payer has the right to raise legal or valuation issues in a timely manner on the appropriate form." (EOB/NF-10)

13. The next several paragraphs discuss the use of modifier -59 and that per the EAPG guidelines this modifier may be used to identify specific separate procedures. Progressive does not dispute that modifier -59 is an appropriate modifier - in specific situations - as outlined in CPC Vinogradov's affidavit.

14. Progressive's original affidavit referred specifically to the modifier -59 National Correct Coding Initiative Policy Manual (NCCI) Edits (Chapter IV Surgery: Musculoskeletal System CPT Codes 20000-29999 section E #4) specific to procedures performed on the shoulder. This specific information indicates, "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 procedure 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 the contralateral shoulders."

15. The three exceptions outlined in the above ground rule are code(s) 29827, 29824 and/or 29828 when billed with code 29823.

16. As explained in Progressive's original affidavit, codes 29821 & 29825 are not listed as possible allowable exceptions when performed on the same shoulder; the modifier is not appropriate and therefore, no payment is warranted.

17. CPC Vinogradov points out the fact that 'separate incisions,' dictate the proper use of modifier -59. I again refer to the above CMS indication that the shoulder is considered a single anatomical region and unless the procedures are performed on the contralateral shoulder, except for three distinct procedure combinations (outlined in #14 & 15 above) the use of modifier -59 to bypass an NCCI edit is improper.

18. CMS indicates in their May 17, 2019 document regarding the use of modifier -59, "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. Modifier -59 should only be used to

identify clearly independent services that represent significant departures from the usual situations described by the NCCI edit. The treatment of contiguous structures in the same organ or anatomic region does not constitute treatment of different anatomic sites." An example outlined in this same CMS document uses codes 29820 & 29827 as examples, with modifier -59 placed on code 29820. The document indicates, "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."

19. CPC Vinogradov indicates that different incisions were used to perform these separate and distinct services. CMS further clarifies proper usage of modifier 59 in their article dated May 17, 2019 page 3: "Arthroscopic treatment of structures in adjoining areas of the same shoulder constitutes treatment of a single anatomic site. #2. Modifier 59 is used appropriately when the procedures are performed in different encounters on the same day. #3. Modifier 59 is used inappropriately if the basis for its use is that the narrative description of the two codes is different. One of the common misuses of modifier 59 is related to the portion of the definition of modifier 59 allowing its use to describe a "different procedure or surgery." The code descriptors of the two codes of a code pair usually represent different procedures, even though they may be overlapping. The edits indicate that the two procedures should not be reported together if performed at the same anatomic site and same patient encounter as those procedures would not be considered to be 'separate and distinct.' The provider should not use modifier 59 for such an edit based on the two codes being different procedures."

20. Again, since codes 29821 and 29825 are not listed as possible allowable exceptions to the NCCI guidelines, modifier -59 would not be appropriate - regardless of the incisions.

21. CPC Vinogradov indicates (#19) based on the 3M EAPG Presentation, the use of modifier -59 "Turns off consolidation - allows separate payment." This is an accurate statement, however, what needs to be remembered is the 3M system is just that, a software system; it will calculate payment based on the information

that it is given. The 3M system is uploaded with the NCCI guidelines/edits to be applied to billing; however, if modifier -59 is submitted on the billing and entered into the software, payment will be allowed and the edits overridden - it's that simple.

22. Progressive is not disputing that modifier -59 is available and can be used in certain situations; however, it is the providers' responsibility to ensure the procedures performed meet the criteria for modifier 59. Since these procedures are not in a different anatomic site or a different encounter, as stated above, modifier 59 would not be appropriate unless the services were performed on different (RT/LT) shoulders OR met the exception criteria outlined previously.

23. The Vinogradov affidavit (#20) addresses the reason for non-payment for codes 64415 and 76942 being a second claim. Codes 64415 and 76942 were, in fact, billed on separate UB forms, therefore this is a separate bill/claim. Pursuant to the Policy and Billing Guidance Ambulatory Patient Groups Provider Manual, Section 3.5 use of Visit and Episode Rate Codes "...All services and procedures provided to a patient with the same date of service and rate code...must be billed together on one claim. If two claims are submitted for the same patient with the same date of service and the same provider...only the first claim will result in payment. The second claim will be denied. If a patient returns to the clinic for multiple visits on the same date of service, all the procedures must be billed on one claim with the appropriate APG rate code...if the provider attempts to submit multiple APG claims for that rate code for the same recipient/same date of service, only one claim will be paid. All others will be denied as duplicative claims...".

24. CPC Vinogradov indicates that the two separate pages signify the difference between the surgeon and the anesthesiologist, however, the billing in dispute is from the facility - not the surgeon or anesthesiologist. In this particular instance, the 'provider/physician' is the facility - an operating room - the person performing the service is not relevant. Based on this, and the above guideline, the submission of two separate bills/claims for services performed on the same date and same operative session is improper.

25. Additionally, regarding codes 64415 / 76942, CPC Vinogradov does not reference The National Correct Coding Initiative Policy Manual For Medicare Services

Chapter VIII Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, and Auditory Systems CPT Codes 60000-69999 Section I #6. Application of the guidelines eliminates the claim for the Nerve Block (CPT code 64415) with Ultra Sound Guidance (CPT code 76942); further NCCI Guidelines concerning CPT Codes 60000-69999 note "...the physician shall not report CPT Codes 64400-64530 for anesthesia for a procedure." As explained previously, since this is the facility billing, and ASCs use the same NCCI edits as physicians, the term physician equates to the facility.

26. Finally, it is outlined in the affidavit that Progressive may have previously allowed payment for this same set of codes billed. Payment on previous billing does not preclude Progressive from applying the NCCI Edits and rules to subsequent bills.

In her award for AAA Case No.: 17-19-1150-2574, my colleague Arbitrator Samiya Mir, was confronted with similar facts. Arbitrator Mir requested an Independent Health Consultant (IHC) review. Arbitrator Mir describes the IHC findings accordingly:

...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.

Regarding CPT 64415, she noted that the patient did not receive general anesthesia but intravenous anesthesia and a regional block, to improve the post-operative recovery. She stated that NCCI guidelines state that certain post-operative pain management procedures may only be separately reportable with anesthesia "if the mode of the

anesthesia is general." She noted that in this case the Assignor did not receive general anesthesia but rather intravenous anesthesia and a "block." She stated that CPT 64415 is a Column 2 code for CPT 29823 and they cannot be reported together even with a modifier based on the NCCI edits.

Lastly, regarding CPT code 76942, she stated that it is reimbursed separately since "EAPG 472 is not included on the NYS DOH Uniform Packaged Ancillaries in APGs." She stated that it should be reimbursed at \$341.96.

In this case, I find the IHC report was thorough and persuasive. As described above, the IHC report was detailed, reviewed and evaluated both parties' affidavits, and cited to numerous sources. The IHC report was consistent with Respondent's fee coder affidavit with regard to CPT codes 29821, 29825, 29819, and 29823, as well as CPT code 64415. The IHC report explained that the 3M software, which Applicant relied upon, could be helpful, but that in this case, manual computation was more accurate. Both the Respondent's affidavit and the IHC report cited to the NCCI edits, which indicated that consolidated modifier 59 was not supported in this case. The IHC report referred directly to the medical reports regarding the shoulder arthroscopy, and explained that modifier 59 was not supported in this case even though multiple incisions were made. The IHC report also explained the appropriate billing for CPT 64415, which was not general anesthesia, but a block to improve post-operative recovery. The IHC report directly addressed Ms. Prajapati's affidavit and explained why her interpretation was incorrect. With regard to CPT 76942, the IHC report persuasively explained that it is reimbursed separately, consistent with and in accordance with Applicant's billing.

In consideration of the IHC report as presented in Arbitrator Mir's award and the coder affidavits submitted by Applicant and Respondent I find that the nerve block under CPT code 64415 is not separately reimbursable from CPT Code 29823 which was previously paid by Respondent. That charge is denied. Applicant is awarded \$341.96 as reimbursement of the charge for ultrasound guidance under CPT Code 76942.

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 LLC	06/25/19 - 06/25/19	\$1,171.26	Awarded: \$341.96
Total			\$1,171.26	Awarded: \$341.96

- B. The insurer shall also compute and pay the applicant interest set forth below. 11/15/2019 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 11/15/19, more than thirty days after receipt of the denial of claim. Therefore, interest shall run effective 11/15/19.

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.

02/22/2021

(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:
db675383cfaf13efbc99e1c426786152

Electronically Signed

Your name: Kevin R. Glynn
Signed on: 02/22/2021