American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Fifth Avenue Surgery Center LLC (Applicant)	AAA Case No.	17-19-1140-2173
	Applicant's File No.	123336
- and -	Insurer's Claim File No.	1030032-02
	NAIC No.	16616
American Transit Insurance Company (Respondent)		

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-C.C.

1. Hearing(s) held on 11/24/2020
   Declared closed by the arbitrator on 03/04/2021

   Sabine Sciarrotto from Samandarov & Associates, P.C. participated by telephone for the Applicant

   Taylor Grogan from American Transit Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 10,710.65**, 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 claim was mailed to and received by Respondent and (ii) Respondent's denial of the subject claim was timely issued.

3. Summary of Issues in Dispute

   The record reveals that the Assignor-C.C., a 19-year-old female, claimed injuries as a passenger of a motor vehicle involved in an accident that occurred on 4/13/2018. Applicant seeks reimbursement for the facility fee billed in relation to right shoulder

arthroscopic surgery conducted on 11/2/2018. Respondent denied the claim based on a lack of medical necessity and lack of causal relationship as per the results of the peer review by Dr. Matthew Skolnick, M.D., dated 6/3/2019. The issues to be determined are 1) whether Applicant's claim is precluded by the doctrine of collateral estoppel, and if not, 2) whether the services are medically necessary and causally related to the accident of 4/13/2018, and 3) 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 billed in relation to right shoulder arthroscopic surgery. 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.

In accordance with 11 NYCRR 65-4.5(o) (1), 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. 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.

COLLATERAL ESTOPPEL

The doctrines of res judicata and collateral estoppel are fully applicable to arbitration proceedings. *See* American Ins. Co., v. Messinger, 43 N.Y.2d 184, 401 N.Y.S.2d 36 (1977). Collateral estoppel is a rule of justice and fairness which mandates that issues once tried should not be re-litigated by a party in a subsequent proceeding who had been afforded a full and fair opportunity to contest the issues raised in a prior proceeding. Commissioners of State Ins. Fund v. Low, 3 N.Y.2d 590, 595, 170 N.Y.S.2d 795, 800 (1958). One of the primary purposes of the doctrine of res judicata is grounded in public policy concerns intended to insure finality, prevent vexatious litigation and promote judicial economy. Matter of Hodes v. Axelrod, 70 N.Y.2d 364 (1987); Matter of Reilly v. Reid, 45 N.Y.2d 24 (1978). Two requirements must be met before collateral estoppel can be invoked. There must be an identity of issue which has necessarily been decided in the prior action and is decisive of the present action, and there must have been a full and fair opportunity to contest the decision now said to be controlling (*see*, Gilberg v. Barbieri, 53 N.Y. 2d 285, 291 [1981]). The party seeking the benefit of collateral estoppel must demonstrate that the decisive issue was necessarily decided in the prior action against a party, or one in privity with a party (*see*, Gilberg v. Barbieri, *supra.*). The party to be precluded from re-litigating the issue bears the burden of demonstrating the absence of a full and fair opportunity to contest the prior determination. Buechel v. Bain, 97 N.Y. 2d 295, 303 (2001). Under New York's transactional approach, as a general rule, "once a claim is brought to a final conclusion, all other claims arising out of the same transaction or series of transactions are barred, even if based upon different

theories or if seeking a different remedy." Parker v. Blauvelt Volunteer Fire Co., Inc., 93 N.Y.2d 343, 347 (1999) *citing* O'Brien v. City of Syracuse, 54 N.Y.2d 353, 357 (1981). The policies underlying the application of res judicata and collateral estoppel are avoiding relitigation of a decided issue and the possibility of an inconsistent result. Notably, the preclusive effect, if any, to be afforded to an earlier decision in a subsequent arbitration proceeding is for the arbitrator of the second proceeding to determine. City School Dist. v. Tonawanda Education Assoc., 63 N.Y.2d 846, 482 N.Y.S.2d 258 (1984).

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).

CAUSATION

Under New York 's Comprehensive Motor Vehicle Insurance Reparation Act (the "No-Fault Law), an insurance carrier is obligated to reimburse an injured party (or his or her assignee), for all "reasonable and necessary expenses" and "medical expenses" arising from the use and operation of the insured vehicle. Unlike negligence actions where claimant must prove causation, claimants seeking No-Fault payments "bear no such initial burden, as causation is presumed." Kingsbrook Jewish Med. Center v. Allstate Ins. Co., 61 A.D.3d 13, 871 N.Y.S.2d 680 (2nd Dept. 2009); Bronx Radiology, P.C. v. New York Central Mutual Fire Insurance Company, 17 Misc.3d 97, 2007 N.Y. Slip Op. 27427 (App. Term 1st Dept. 2007).

Causation is presumed since "it would not be reasonable to insist that (an applicant) must prove as a threshold matter that (a) patient's condition was 'caused' by the automobile accident." Mount Sinai Hospital v. Triboro Coach, 263 A.D.2d 11, 20, 699 N.Y.S.2d 77 (2nd Dept. 1999). Thus, the burden is on the insurer to come forward with proof establishing by "fact or founded belief" its defense that the claimed injuries have no nexus to the accident. Mount Sinai Hospital v. Triboro Coach, 263 A.D.2d 11, 19 (2nd Dept. 199) (*quoting* Central Gen. Hosp. v. Chubb Group of Ins. Cos., 90 N.Y. 2d 195, 199 (1997).

The case law holds that for respondent to show that a patient's treated condition was unrelated to his or her automobile accident, the affidavit of its medical expert must be supported by the evidence and not be conclusory or speculative. E.g., New York & Presbyterian Hospital v. Selective Ins. Co. of America, 43 A.D.3d 1019, 842 N.Y.S.2d 63 (2d Dept. 2007). Once Respondent provides proof that the condition was unrelated to the accident, the burden shifts to the Applicant to address such proof. Pommells v Perez, 4 NY3d 566, 577-578, 830 NE2d 278, 797 NYS2d 380 [2005]; *See also* Campbell v. Drammeh, 2018 NY Slip Op 03643 [161 AD3d 584] andLatus v Ishtarq, 2018 NY Slip Op 01417 (1st Dept. 2018) [Plaintiff's physician provided only a conclusory opinion that plaintiff's injuries were caused by the accident, without addressing the preexisting conditions documented in his own MRI, or explaining why plaintiff's current reported symptoms were not related to the preexisting conditions (*see Nakamura v Montalvo*, 137 AD3d 695, 696 [1st Dept 2016];*Farmer v Ventkate Inc.*, 117 AD3d 562, 562 [1st Dept 2014]).]

"Exacerbations of preexisting conditions are covered by the No-Fault Law (see Wolf v Holyoke Mut. Ins. Co., 3 AD3d 660, 660-661 [2004]; Mount Sinai Hosp. v Triboro Coach, 263 AD2d at 18), Kingsbrook Jewish Medical Center v. Allstate Ins. Co., 871 N.Y.S.2d 680, 61 AD3d 13, 2009 NY Slip Op 351 (N.Y. App. Div., 2009).

Neither a failure to disclaim nor the issuance of a denial untimely on its face, preclude the Respondent from resisting a claim and asserting that its policy did not contemplate coverage in the first instance. (*See*, Cent. Gen. Hosp. v. Chubb Group of Ins. Cos., 90 N.Y.2d 195, 201 - 202 [N.Y. 1997]; see also, Fair Price Med. Supply Corp. v. Travelers Indem. Co., 10 N.Y.3d 556 [N.Y. 2008]) St. Vincent's Hospital & Medical Center v. Allstate Ins. Co., 69 A.D. 3d 923, 893 N.Y.S.2d 589 (2d Dept. 2010).

Application of Legal Standards

Right shoulder arthroscopic surgery was conducted on 8/2/2018. In support of its contention that the right shoulder arthroscopic surgery and services performed in relation to the surgery were not medically necessary or causally related to the accident of 4/13/2018, Respondent relies upon the peer review of Dr. Matthew Skolnick, M.D., dated 6/3/2019, and independent radiology review of the MRI of the right shoulder by Darren Fitzpatrick, M.D., dated 8/22/2018. Applicant submitted a formal rebuttal by W. Joseph Gorum, M.D., dated 5/27/2020.

In *W. Joseph Gorum MD P.C. v. ATIC,*AAA Case No.: 17-19-1137-5996 and *Igor Amigud Physician, P.C. v. ATIC,*AAA Case No.: 17-19-1140-2207, both also heard on 11/24/2020, I was asked to address the medical necessity and the causal relationship of the services billed to the accident for the surgeon's fee, physician assistant's (PA) fee and anesthesia provided in relation to the right shoulder surgery that was conducted on 8/2/2018. Upon consideration of the submitted medical records, the same peer review of Dr. Matthew Skolnick, M.D., dated 6/3/2019, and independent radiology review of the MRI of the right shoulder by Darren Fitzpatrick, M.D., dated 8/22/2018, and a rebuttal affirmation from the treating physician, I found that the surgery was medically necessary and causally related to the accident of 4/13/2018. Specifically, I determined the following in AAA Case No.: 17-19-1137-5996, in pertinent part:

> *Summary of Issues in Dispute*
> *The record reveals that the Assignor-C.C., a 19-year-old female, claimed injuries as a passenger of a motor vehicle involved in an accident that occurred on 4/13/2018. Applicant seeks reimbursement for the surgeon and physician assistant's fee for right shoulder arthroscopic surgery conducted on 8/2/2018. Respondent denied the claims based on a lack of medical necessity per the results of the peer review by Dr. Matthew Skolnick, M.D., dated 6/3/2019. The issue to be determined is whether the services were medically necessary and causally related to the accident of 4/13/2018?*
> *Findings, Conclusions, and Basis Therefor*
> *Applicant seeks reimbursement for the surgeon and physician assistant's fee for right shoulder arthroscopic surgery…*
> …

Application of Legal Standards

The Assignor had right shoulder arthroscopic surgery on 8/2/2018. In support of its contention that the services were not medically necessary or causally related to the accident of 4/13/2018, Respondent relies upon the peer review of Matthew Skolnick, M.D., dated 6/3/2019, and the independent radiology review of the MRI of the right shoulder by Darren Fitzpatrick, M.D., dated 8/22/2018. Applicant submitted a formal rebuttal by W. Joseph Gorum, M.D., dated 5/27/2020.

Dr. Skolnick noted in pertinent part:

> *Thesurgery ofthe rightshoulder wasperformed by Dr.Gorum on 08/02/18. Accordingto the providedmedicalrecords,the claimant was evaluated by Dr.Gorum on05/21/18-07/18/18for complaints ofrightshoulder pain. On 07/18/18,physical examinationof the rightshoulderrevealedtenderness andlimitedrange ofmotionwith slightlydecreased motorstrength.Impingementsigns, Speed's and Yergason'swere positive and all other special testsperformedfor theshoulder werenegative.No effusion, crepitus orinstabilitywas reported. Surgery of therightshoulder wasindicated by Dr. Gorum and theprocedurewasperformedon 08/02/18.*
>
> *Furthermore,the MRIofthe rightshoulderperformed on 06/23/18 revealed norotator cuff orlabral tear.Also, accordingto the radiology reviewofthisstudyby Dr.Fitzpatrick,theMRIwas unremarkableandnoevidenceof traumatic injurywas seen.*
>
> *Basedontheabove,there is notadequatemedical indication to justify thesurgery ofthe rightshoulder.In addition,there is no evidence that this claimant'sright shoulder was deteriorating despiteconservativetreatment.*
>
> *…*
>
> *Therefore,thesurgery oftheright shoulder with associated servicesincludingprescription medicationandpost-operative supplies on07/31/18-09/07/18 werenot medically necessaryor causallyrelatedto the accidentof record. Inaddition,basedonmy opinion thatthesurgery wasnot medically necessary,any derivativeservicesrelatedto,or as aresultof the surgery,including medicalsupplies,should also be denied.*
>
> *The AMA (American Medical Association)defines medical necessity as, "Health care services orproducts thataprudent physicianwouldprovide to a patientforthe purposeofpreventing, diagnosing, or treatinganillness, injury,disease or itssymptomsin amanner that is(a)inaccordance with generally accepted standards ofmedicalpractice; (b)clinicallyappropriatein termsof type, frequency, extent,site, andduration;and (c)not primarilyfor the convenience ofthe patient,physician,or otherhealthcare provider."(American Medical Association,January 14, 2011, "Statement ofthe American Medical Association to the Instituteof Medicine'sCommittee onDeterminationof EssentialHealth Benefits").*

Dr. Fitzpatrick performed an independent MRI review, dated 8/22/2018, wherein he noted that the MRI was conducted more than two months after the accident on 6/23/2018. The findings were "normal marrow signal. Rotator cuff and biceps tendon are intact. Normal musculature. The glenohumeral and acromioclavicular are preserved. The labroligamentous are intact. No fluid collection or effusion". Dr. Fitzpatrick's impression was this was an unremarkable shoulder MRI and his conclusion was no traumatic injury was present. There is no indication that Dr. Skolnick made his own independent review and assessment of the MRI study; rather, it appears that he simply relied on the prior review by Dr. Fitzpatrick to reach his conclusion.

On its own, I find the radiology review insufficient to establish lack of causation since the same lacks medical analysis, citation, comparative analysis of the original MRI study or any explanation of its latter conclusion.

I find Respondent's peer review insufficient to meet Respondent's burden of persuasion with respect to lack of medical necessity defense because it failed to set forth a sufficient factual basis and medical rationale. The peer review lacked objective medical reasoning and citation to relevant medical authority. Although the peer review listed the positive findings in Dr. Gorum's exam, Dr. Skolnick ignored the same when rendering his analysis to deny the surgery. He notes that based on the MRI, which he noted was unremarkable, and Assignor's response to conservative treatment, which he noted did not show deterioration, the surgery was not necessary but does not reference any specific medical report or citation to support this position. I further find Dr. Skolnick's findings conclusory and wholly unsupported by the record. Dr. Skolnick fails to establish a standard of care for performing the surgery or establish that the standard of care was not met. Dr. Skolnick's only citation is to the generic AMA definition of medical necessity in his peer review, which does not meet the Nir [1]standard. In sum, I find the peer review by Dr. Skolnick unpersuasive and conclusory. Respondent failed to "support its lack of medical necessity defense" and the "burden of persuasion" did not therefore shift to applicant. See generally, Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006).

With respect to the alleged lack of causation, Respondent also failed to meet its burden to support its defense. The case law holds that for Respondent to establish that a patient's treated condition was unrelated to his or her automobile accident, the affidavit of its medical expert must be supported by the evidence and not be conclusory or speculative. E.g., New York & Presbyterian Hospital v. Selective Ins. Co. of America, 43 A.D.3d 1019, 842 N.Y.S.2d 63 (2d Dept. 2007). Respondent's peer fails to meet this standard. Dr. Skolnick relies on the independent report of Dr. Fitzpatrick, which noted no post-traumatic injury, but ignores complaints regarding the right shoulder since the accident, failed conservative treatment, consistent examinations by orthopedist Dr. Gorum, which established positive clinical objective findings, and operative findings, which correlate with the examination findings. Dr. Skolnick was given the examination reports,

physical therapy records, MRI report, and the operative report to review and chose to rely on the independent peer doctor's analysis rather this own independent analysis. Both Dr. Fitzpatrick and Dr. Skolnick fail to support the conclusion that the injuries were unrelated to the instant motor vehicle accident as no credible explanation, medical authority or analysis were rendered on the same. Dr. Skolnick failed to establish the services at issue were rendered for a condition that was completely unrelated to the accident. Moreover, if the Assignor did have a pre-existing condition Dr. Skolnick failed to explain that the accident did not aggravate or exacerbate the Assignor's medical condition.

Notably, even if the peer review was sufficient to shift the burden, Applicant's rebuttal, and medical records, including Dr. Gorum's examinations, dated 5/21/2018, 7/3/2018, and 7/18/2018, and records of conservative care prior to the surgery, which showed lack of improvement, meet the burden of persuasion and establish the medical necessity of the surgery and the causal relationship of the right shoulder surgery billed to the accident. The issues raised by the peer review were addressed and rebutted by the Applicant's rebuttal and medical records.

Accordingly, Applicant's claim is granted in its amended entirety. This award is in full disposition of all No-Fault benefit claims submitted to this Arbitrator.

I find that the standard for Collateral Estoppel is met in this case. There is an identity of issues between the cases, namely, whether the underlying right shoulder surgery, for which the related service of the facility fee for the nerve block injection in dispute was provided, was medically necessary and causally related to the accident. Considering my prior awards, it would be inconsistent for me to find Respondent's denial in this case can be sustained. Respondent had a full and fair opportunity to contest the prior decisions, prosecuted the claims on the merits, and decisions were made on the merits, which were not appealed. Respondent presented identical evidence, which was reviewed and considered, including the peer review of Dr. Matthew Skolnick, M.D., dated 6/3/2019, and independent radiology review of the MRI of the right shoulder by Darren Fitzpatrick, M.D., dated 8/22/2018. I determined that Respondent failed to sustain its burden for the defenses of lack of medical necessity and lack of causal relationship. I further determined that the peer review cited to no medical authority to support his position. As such, Respondent failed to shift the burden to Applicant to establish the medical necessity or the causal relationship of the services to the accident. I find that Respondent's counsel has not sufficiently satisfied its burden to show the absence of a full and fair opportunity to litigate the issue of medical necessity and causal relationship of the services in relation to the underlying right shoulder surgery and related services, including the facility fee for the right shoulder surgery in dispute based on the peer review of Matthew Skolnick, M.D., dated 6/3/2019.

Since I previously determined that the Respondent failed to sustain its burden of demonstrating that the subject treatment and related services were not medically necessary and not causally related to the accident, I am bound by the doctrine of collateral estoppel. The issues in the instant case and in the linked cases decided by me are identical, and therefore, the instant claim is denied under the doctrine of collateral

estoppel, thus precluding the Respondent from re-litigating that issue in the instant matter.

I further concur with my decisions that the peer review failed to cite to any medical authority or sufficient medical rationale to sustain its defenses and therefore failed to shift the burden to Applicant to establish the medical necessity or causal relationship of the services billed to the accident.*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). Respondent failed to "support its lack of medical necessity defense" and the "burden of persuasion" did not therefore shift to Applicant. *See generally*, Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006).

Therefore, I find that the Respondent has not met its burden of proving that the medical care in dispute was not medically necessary for the subject patient or proving that the services were not causally related to the accident. Therefore, the claim is granted and the issue to be determined is whether Applicant billed the services in accordance with the applicable fee schedule?

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 billed $10,710.65 for the facility fee for right shoulder arthroscopy conducted on 8/2/2018 billed under codes 23406, 29819, 29821, 29823, 29825, 29826, and 20610.

There were two linked cases before me today *Fifth Avenue Surgery Center v. ATIC,* AAA Case Nos.: 17-19-1140-2173 and 17-19-1140-2159, which seek reimbursement for the facility fee for the right shoulder surgery ($10,710.65) and a brachial plexus injection under ultrasonic guidance ($1,171.26) conducted on 8/2/2018. While Respondent did not raise any fee schedule defenses, I believed it appropriate to forward these disputes to an IHC made available to arbitrators for multiple issues, including fee schedule analysis.

The parties agree that the New York State Worker's Compensation Fee Schedule is applicable to the instant claim.

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.

I acknowledge I received a report, dated 1/15/2021, from the IHC consultant, Ms. Joyce Ehrlich, MS, MPA, CPMA, CPCO, CEMA, CPB, a Certified Professional Medical Auditor, credentialed by the American Academy of Professional Coders ("AAPC") with ten years' experience in medical auditing, which indicated that the maximum reimbursement for the services billed is $6,056.61. 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.

> Operative Procedures:
> 29805 - Diagnostic arthroscopy, shoulder
> "A comprehensive arthroscopic examination of the shoulder was performed…"
> 29819 - Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
> "One loose body was present. The loose body was located in the axillary pouch. Removal of loose body procedure was performed."
> 29821 - Arthroscopy, shoulder, surgical synovectomy, complete
> "Synovitis was present. The synovitis was affecting the labral and rotator cuff. A synovectomy procedure was performed."
> 29823 - Arthroscopy, shoulder surgical debridement, extensive
> "Labral tear was present. The tears were non-repairable. A debridement procedure was performed. The torn tissues were debrided using the shaver and arthroscopic want were utilized to debride and smooth out the tissues".
> 29825 - Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation
> "Adhesive capsulitis was present. The adhesions from the inflammation and bursitis were affecting the subacromial space. Lysis of adhesions procedure was performed. A shaver and arthroscopic want were used to lyse and remove the adhesions".
> 29826 - Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament release, when performed
> "Impingement was present. Excessive inflammation, adhesions and bursitis contributed to the subacromial impingement. A subacromial decompression procedure was performed. A shaver and wand were used to excise and excessive inflamed tissue decompressing the subacromial space.

20610 - Arthrocentesis, aspiration and/or injection, major joint or bursa; without ultrasound guidance
"The shoulder joint was then injected with Lidocaine and Marcaine solution".

Ms. Ehrlich noted in pertinent part under **Resource Guidelines**: In order to calculate the correct reimbursement for each CPT code, the following source material was referenced:

1. NYS DOH APG-Based Weights History File
2. NYS HCPCS codes with EAPG Assignment (version 3.15) -3M™ Enhanced Ambulatory Patient Groups (EAPGs)"

I arrived at the EAPG amount using the DOH rate files available to perform this function manually. It is accepted in the industry to perform this computation manually and the resources exist online to look up the EAPG group for each CPT code, as well as the weight for each cross-walked APG group. In defense of calculating the EAPG reimbursement manually, I offer the following reference:

Source: Workers' Compensation Enhanced Ambulatory Patient Group (EAPG) Ambulatory Surgery Fee Schedule FAQs #8:

"Does the 3M Core Grouper software calculate inpatient and outpatient bills? 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."

Based on the above sources, the EAPG computation may be performed manually, and the 3M product is not absolutely required to make the necessary calculations.

Use of Modifier - 59

2. While the New York State Workers' Compensation Board permits unbundling using modifier -59 and use of the modifier turns of consolidation (allows separate reimbursement), the use of a modifier must be justified by the documentation (operative report). Based on the operative report, modifier -59 should not have been appended to any of the codes.
3. Justifying the use of modifier 59 based 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.
    a. The AMA CPT manual defines modifier -59 as follows: "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. However, when another already established modifier is appropriate, it should be used rather than modifier -59. Only if no more descriptive modifier is available, and the use of modifier -59 best explains the circumstances, should modifier 59 be used".

4. Based on the following excerpt from the following CMS website, the use of modifier -59 in the case of arthroscopic surgery of the shoulder is incorrect.

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/modi

"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." One of the common uses of modifier 59 is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed at different anatomic sites, are not ordinarily performed or encountered on the same day, and that cannot be described by one of the more specific anatomic NCCIassociated modifiers - i.e., RT, LT, E1-E4, FA, F1-F9, TA, T1-T9, LC, LD, RC, LM, or RI. (See examples 1, 2, and 3) 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. Therefore 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. 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)

Modifier -59 is used appropriately for diferent 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".

Separate incisions do not qualify as separate procedures, and therefore use of modifier -59 is 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 incisions created on the posterior portal, the lateral portal, and the anterior portal are all intrinsic to an arthroscopy of the shoulder. In addition, incisions were made to complete procedures which are not reimbursed separately.

5. Sources justifying use of NCCI and PTP edits -

a. Source: Transition to Enhanced Ambulatory Patient Groups, October 1, 2015 implementation - "2015 Software Preference and Edits - NCCI edits are to be used"

b. Source: Workers' Compensation Enhanced Ambulatory Patient Group (EAPG)

Ambulatory Surgery Fee Schedule FAQs

22. Which NCCI edits are used?

Hospital outpatient NCCI edits and Medical Unlikely Edits are used.

Use of NCCI PTP Edits

6. Each active NCCI edit has a modifier indicator of 0 or 1. A modifier indicator of "0" indicates that an edit can never be bypassed even if a modifier is used. In other words, the Column 2 code of the edit will be denied. A modifier indicator of "1" indicates that an edit may be bypassed with an appropriate modifier appended to the Column 1 and/or Column 2 code.

a. The Column 1/Column 2 tables are comprised of PTP code pairs. If a provider submits the two codes of an edit pair for payment for the same beneficiary on the same date of service, the Column 1 code is eligible for payment and the Column 2 code is denied. However, if both codes are clinically appropriate and an appropriate NCCI-associated modifier is used, the codes in both columns are eligible for payment.

b. Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass a PTP code pair edit if the clinical circumstances do not justify its use.

There are no conflicting edits for significant procedure code 23406, therefore this code may be billed with all the other codes on the bill.

Ms. Ehrlich provided a chart with the NCCI edits for procedure, CPT 29823, which indicates that code 29823 is a Column 1 code for Column 2 codes 29819, 28920, 28921, 29822, 29825 with Modifier 1, which means allowed when circumstances are met, and a PTP/Edit Rationale of More Extensive Procedure.

7. The 3M Software 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 from 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.

Fee Schedule Analysis:

1. Consolidating - Excerpt from Policy and Billing Guidance Ambulatory Patient Groups (APGs) Provider Manual REVISION 2.1 August 2012: Significant Procedure Consolidation: Significant procedure consolidation refers to the collapsing of multiple related significant procedure APGs into a single APG for the purpose of determining payment. The APG system relies on a significant procedure consolidation list developed on the basis of clinical judgment which identifies for each significant procedure APG, the other significant procedure APGs that are an integral part of the procedure and which can be performed with relatively little additional effort. The APG grouping logic consolidates related significant procedures. (Example: a Level I (primarily diagnostic) lower gastrointestinal endoscopy is consolidated into the Level II (primarily therapeutic) gastrointestinal endoscopy.) Unrelated significant procedures are not consolidated. Multiple unrelated significant procedures on the same date of service also are not consolidated in the APG classification system, but payment for additional unrelated significant procedures will be discounted.
2. Code 29825 is a column 2 code for 29823 with an indicator "1". This means that the use of modifier -59 is allowed when circumstances are met. Based on documentation and rules regarding reporting lysis of adhesions separately from debridement, the use of modifier -59 to override the edit is not allowed and therefore, 29825 is included in CPT 29823. If the physician performs both procedures on the right shoulder and bills the procedures together, they're considered bundled services and as such, only CPT 29823 will be reimbursed since the lysis of adhesions is part of a more extensive procedure. CPT 29825 is not separately reimbursed.

3. CPT Code 29821 is a column 2 code with an indicator "1" when billed with CPT 29823. This means that an edit may be bypassed with an appropriate modifier appended to the Column 1 and/or Column 2 code, when circumstances are met.

   However, in order to report CPT 29821, "The entire intra-articular synovium must be removed". This is not clearly documented in the operative report.

   Source: CPT Assistant June 2013; Volume 23: Issue 6

   Question: CPT code 29821 describes a complete synovectomy of the shoulder performed arthroscopically. In order to be considered a complete synovectomy, does the entire intra-articular synovium need to be removed?

   Answer: Yes. Code 29821, Arthroscopy, shoulder, surgical; synovectomy, complete, is reported for a complete synovectomy

for a synovitic disease, such as rheumatoid arthritis or pigmented villonodular synovitis, with removal of the entire intra-articular synovium.

The operative report simply states that "Synovitis was present (in the glenhumeral compartment). The synovitis was affecting the labral and rotator cuff. A synovectomy procedure was performed". Based on this documentation, it is not clear that the entire intra-articular synovium was removed. Additionally, the provider does not document any diagnosis that would be compatible with a complete synovectomy, such as villonodular synovitis.

Source: CPT Assistant December 2010:

"It is always important that the CPT code reported accurately describe the service that was performed".

Based on the documentation, there is insufficient support for CPT 29821. Based on documentation, CPT code 29821 is not reimbursed separately from the debridement CPT 29823.

4. CPT 29819 - CPT 29819 is a column 2 code with an indicator "1" when billed with CPT 29823. This means that an edit may be bypassed with an appropriate modifier appended to the Column 1 and/or Column 2 code, when circumstances are met.

   Based on the documentation in the operative report, the provider states "One loose body was present. Removal of loose body procedure was performed".

   Source: The December 2016 CPT Assistant states that an extensive debridement "additionally includes removal of osteochondral and/or chondral loose bodies, biceps tendon and rotator cuf debridement, and abrasion arthroplasty".

   There is no separate reimbursement for CPT 29819.

5. CPT 29826 - In order to bill for CPT 29826 the following procedures need to be performed; a decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie. arch) release, when performed. This is an add-on code and must be billed in addition to the primary procedure.

   Source: CPT Assistant, March 2015, Volume 25, Issue 3

   "A review from the AMA/Specialty Society RVS Update Committee (RUC) was conducted to address the use of code 29826 because the code had been billed more than 95% of the time with other arthroscopic shoulder repair codes. A recommendation was made to convert code 29826 to an add-on code to better manage the use of this code rather than relying on multiple procedure reduction rules. Therefore, in the 2012 CPT code set, code 29826 was converted to an add-on code, which by definition requires that the procedure be billed with other primary procedures. The CPT codes that may be reported with code 29826 are 29806, 29807, 29819, 29821, 29822, 29823, 29824, 29825, 29827, and 29828".

   Based on the above, CPT 29826 may be billed as an add-on to CPT 29823 and reimbursed separately.

Note: While I am inclined to allow for reimbursement for this procedure, it should be noted that the documentation supporting this procedure is lacking. The provider merely states that a subacromial decompression procedure was performed and that a shaver and wand was used to excise excessive inflamed tissue decompressing the subacromial tissue. He does not state that he performed a partial acromioplasty, which is part of the procedure described by CPT 29826.

6. CPT 20610 - As per Appendix E of the EAPG Fee Schedule, CPT 20610 has an APG assignment of 49. All APG 49 are inclusive of the significant procedure performed. Therefore, there is no additional reimbursement for this procedure.
7.

Source: The December 2007 CPT Assistant made an important distinction for joint injections. It states:

> Question: If a surgical arthroscopy of the knee is performed (29870-29889) and after withdrawal of the scope and portal suture the surgeon injects bupivacaine for post-operative pain management directly into the knee joint, may code 20610 be reported in addition to the CPT code for the specific arthroscopic procedure performed?
>
> Answer: Code 20610 [Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa)], should not be reported when performed concurrent with another intra-articular procedure (e.g., knee arthroscopy). However, should the bupivacaine injection be performed at an anatomic site other than that of the knee arthroscopy, then the appropriate code from the 20600-20610 series should be reported, as appropriate, with modifier -59 (distinct procedural service) appended.

8. In summary, according to Chapter IV, Surgery: Musculoskeletal System of the National Correct Coding Initiative Policy Manual for Medicare Services, Section E. Arthroscopy, "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." This case does not meet any of the exceptions to the NCCI edit.

Therefore, CPT code 23406 (billed at $3,111.70), EAPG Group 31, EAPG Weight 10.23, Correct Reimbursement: $3030.33+81. 37 (capital add-on) = $3,111.71.

CPT code 29823- RT-59 (billed at $1472.45), EAPG Group 37, EAPG Weight 9.9509, Correct Reimbursement: Full payment $1,472.45

CPT code 29826- RT-59 (billed at $1472.45), EAPG Group 37, EAPG Weight 9.9509 x .50 = 4.9754 Consolidated, Correct Reimbursement: Full payment $1,472.45
Total Reimbursement: $6,056.61. CPT Codes 29819-RT-59, 29821-RT-59, 29825-RT-59, and 20610-RT-59 are not reimbursable.

Post-IHC

On receipt of this report and forwarding to both parties, I note that both Applicant and Respondent were given time to respond, which Applicant did.

Applicant indicates it is entitled to the amount of $10,710.65. Applicant has submitted an Affirmation by Aaron J. Perretta, Esq., who is employed with Applicant's counsel, but who is also identified as a CPC. Applicant relies on Modifier 59 in support of its position.

Applicant argues that in the instant matter that Ms. Ehrlich improperly relied upon the CPT Assistant as an extrinsic source as it has not been expressly adopted by the EAPG Framework. Moreover, Ms. Ehlrich did not utilize the 3M software, which is "expressly endorsed by the New York State Workers' Compensation Board", but rather performed the calculations manually. Moreover, the pertinent portion of the Procedure-to-Procedure ("PTP") Edits demonstrates the lines containing the NCCI PTP Edit pairs of 29823/29819, 29823/29821, and 29823/29825 contain a "1" within their respective "Modifier Indicator" columns. As per the Modifier column, it states, "1 = allowed," indicating Codes 29819, 29821 and 29825 are absolutely 'allowed' to be coded together with 29823 when the appropriate modifier is appended to Codes 29819, 29821 and 29825." Furthermore, Applicant states Applicant's bill and operative report stand for the position that its use of Modifier 59 in this instance permits CPT Codes 29819, 29821 and 29825 to be properly coded with CPT Code 29823, per the AMA's descriptor of same as it is clear three separate incisions and seven separate procedures were performed. "Applicant believes it properly demonstrated to this arbitrator that it did not appended Modifier 59 simply to bypass an NCCI Edit, but instead appended Modifier 59 so as to most accurately report the services performed in this surgical setting". Applicant argued that Modifier 59 was properly utilized, and they are therefore entitled to reimbursement for the services billed.

Applicant further argues that if further information was required by Respondent to substantiate the billing, then verification should have been requested as "Respondent possesses a statutory duty to request ANY information it deemed necessary or 'not clear' before processing and ultimately denying this claim, via a verification request and follow-up request pursuant to 11 NYCRR §§ 65-3.5, 65-3.6(b)". and "Bronx Acu. Therapy v. Hereford, 2019 NY Slip Op (App. Div., 2nd 2019)".

CONCLUSION

Judicial notice of the New York fee schedule is taken. In light of the expertise of Ms. Ehrlich, who provided a detailed analysis of the codes in dispute, I find it to be persuasive in terms of reimbursement.

I find the IHC's calculations, based on a clear reading of the 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. 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 Ms. Ehrlich's calculations have established by a preponderance of credible evidence the proper fee schedule amount for the services billed in accordance Workers' Compensation Enhanced Ambulatory Patient Group (EAPG) Ambulatory Surgery Fee Schedule.

Contrary to Mr. Perretta's arguments that Ms. Ehrlich should be required to utilize the 3M Software to calculate the bills, Ms. Ehrlich refers to the Workers' Compensation EAPG, Ambulatory Surgery Fee Schedule FAQs, Question 8, which states that the calculations may be performed manually. Specifically, it states:

> Does the 3M Core Grouper software calculate inpatient and outpatient bills?
> 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.

Mr. Perretta provides a copy of the FAQs as an exhibit to the Affirmation in Opposition.

Ms. Ehrlich based her fee schedule analysis on the Documents, Source Materials, and Resource Guidelines, including Applicant's submission of the bill and operative report. Her analysis is based on the specific language included in these documents, which she cites to. Regarding code 29826 Ms. Ehrlich recommends reimbursement despite the lack of complete documentation stating: "While I am inclined to allow for reimbursement for this procedure, it should be noted that the documentation supporting this procedure is lacking. The provider merely states that a subacromial decompression procedure was performed and that a shaver and wand was used to excise excessive inflamed tissue decompressing the subacromial tissue. He does not state that he performed a partial acromioplasty, which is part of the procedure described by CPT 29826". As Respondent did not dispute Applicant's bill for this code or Ms. Ehrlich's recommendation for reimbursement, this code was granted. Regarding the remaining codes, Ms. Ehrlich did not indicate that codes were denied based on lack of documentation. Reimbursement was recommended based on the procedures that were performed and the EAPG Guidelines.

Regarding the use of the CPT Assistant as a coding resource, On October 1, 2015 "the Workers' Compensation Board transitions from the Products of Ambulatory Surgery (PAS) based ambulatory surgery fee schedule to the Enhanced Ambulatory Patient Groups (EAPG) methodology to coincide with the implementation of ICD-10 diagnosis codes". *See* N.Y. Comp. Codes R. & Regs. tit. 12, § 329- 2.1; http://www.wcb.ny.gov/content/main/hcpp/MedFeeSchedules/EAPGTransitionDocu-men
.

The Worker's Compensation EAPG Implementation Guide, which includes the NYS WCB specific base rates, indicates EAPG 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. Other factors, including the provider's location and certain "add-on" costs, also affect the total allowable reimbursement. *See* wcb.ny.gov/content/main/hcpp/MedFeeSchedules/EAPGImpGiuide.pdf

Pursuant to the NYS Department of Health Policy and Billing Guidance Ambulatory Patient Groups (APGs) Provider Manual: Glossary of Terms: "HCPCS Codes - The Healthcare Common Procedure Coding System. A numeric coding system maintained by the American Medical Association (AMA) used to identify services and procedures for purposes of billing public or private health insurance programs. CPT (Common Procedure Terminology) codes are a subset of the HCPCS coding system".

Furthermore, pursuant to Section 3.13 EAPG DEFINITIONS MANUAL AND EAPG GROUP/PRICER: "Providers may wish to obtain a copy of the 3M EAPG Definition manual to understand how CPT codes map to APGs. 3M's EAPG Definitions Manual is available through the 3M's Definitions Manual Website. Please see: http://solutions.3m.com/wps/portal/3M/en_US/3M_Health_Information_Systems/HIS/Pro 3M also offers the EAPG Grouper/Pricer. The Grouper/Pricer is one integrated software tool. The grouper component assigns CPT and HCPCS codes to APGs; and the pricer component applies the appropriate weights and base rates and other payment rules to the APGs. The APG Grouper/Pricer software will be updated at least twice each year to accommodate updates of ICDâ9 diagnosis codes, CPT and/or HCPCS codes and revisions in pricer logic".

Applicant argues that the CPT Assistant has not been expressly adopted as a coding resource by the EAPG Framework. Regarding the CPT Assistant, the American Medical Association, states in an article titled "*Need Coding Resources?*" which states in pertinent part" "Trusted for more than 50 years, the Current Procedural Terminology (CPT®) code set drives communication across health care by enabling the seamless processing and advanced analytics for medical procedures and services. CPT® is also the code to medicine's future. Constantly updated by the CPT® Editorial Panel with insight from clinical and industry experts, the CPT® code set reflects the latest innovations and helps to improve the delivery of care. The American Medical Association (AMA) has several resources to help accurately bill procedures and services with the Current Procedural Terminology (CPT®) code set and Healthcare Common Procedure Coding System (HCPCS) codes." Two coding resources listed include 1) "CPT® Professional Edition: Only the AMA, with the help of physicians and other health care experts, create and maintain the CPT code set, and only CPT® Professional Edition can provide the official guidelines to code medical services and procedures properly. Users can also request a CPT Data File license, which makes it easy to import codes and descriptions into electronic systems" and 2) CPT® Assistant: "The official online and print industry newsletter with proper CPT® coding education and guidance for past, present and future code set releases. Articles address the latest medical codes

and trends; clinical scenarios; FAQs and anatomical and procedural illustrations, charts and graphs". *See* https://www.ama-assn.org/practice-management/cpt/need-coding-resources.

Applicant relies on the AMA Professional Edition CPT (*see* paragraph 38 of Applicant's Affirmation in Opposition) but argues that the CPT Assistant is not a valid resource. The AMA specifically states that the "The American Medical Association (AMA) has several resources to help accurately bill procedures and services with the Current Procedural Terminology (CPT®) code set and Healthcare Common Procedure Coding System (HCPCS) codes", which includes both the AMA Professional Edition and the CPT Assistant. Moreover, the NYS Department of Health Policy and Billing Guidance Ambulatory Patient Groups (APGs) Provider Manual, Section 3.13 EAPG DEFINITIONS MANUAL AND EAPG GROUP/PRICER indicates "The APG Grouper/Pricer software will be updated at least twice each year to accommodate updates of ICDâ9 diagnosis codes, CPT and/or HCPCS codes and revisions in pricer logic". The APG Pricer Software is updated based on updates to various sources including to CPT codes. The AMA specifically references the CPT Assistant as a valid coding resource.

I disagree with Applicant's reading of Matter of Global Liberty Ins. Co. v McMahon, 2019 NY Slip Op 03692 Decided on May 9, 2019 Appellate Division, First Department, which is directly on point to this issue, and states in pertinent part:

> The Official New York Workers' Compensation Medical Fee Schedule, promulgated by the chair of the Workers' Compensation Board, directs users to "refer to the CPT book for an explanation of coding rules and regulations not listed in this schedule." The CPT book, in turn, expressly makes reference to CPT Assistant. By both statute and regulation, the fee schedules established by the chair of the Workers' Compensation Board are expressly made applicable to claims under the No-Fault Law (see Insurance Law § 5108; 11 NYCRR 68.0, 68.1[a][1]; see generally Government Empls. Ins. Co. v Avanguard Med. Group, PLLC, 127 AD3d 60, 63-64 [2d Dept 2015], affd 27 NY3d 22 [2016]). Accordingly, because CPT Assistant is incorporated by reference into the CPT book, which is incorporated by reference into the Official New York Workers' Compensation Medical Fee Schedule applicable to this claim under the No-Fault Law, the award rendered without consideration of CPT Assistant [*2]is incorrect as a matter of law (see 11 NYCRR 65-4.10[a][4]). We therefore grant the petition to vacate the award and remand the matter to the lower arbitrator for a new arbitral proceeding, at which relevant portions of CPT Assistant shall be given due consideration.

Accordingly, Applicant's claim is granted in the amount of $6,056.61. 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**
	Fifth Avenue Surgery Center LLC	**08/02/18 - 08/02/18**	**$10,710.65**	**Awarded: $6,056.61**
Total			**$10,710.65**	**Awarded: $6,056.61**

B. The insurer shall also compute and pay the applicant interest set forth below. 09/02/2019 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.

04/05/2021
(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:
570abe47287ad9bd61c95db7e8962a83

Electronically Signed

Your name: Eileen Hennessy
Signed on: 04/05/2021