American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Surgicore Of Jersey City, LLC (Applicant)	AAA Case No. 17-20-1175-2635
	Applicant's File No. SS-146920
- and -	Insurer's Claim File No. 32-B436-3G3
	NAIC No. 25178
State Farm Mutual Automobile 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-M.C.

1. Hearing(s) held on 07/06/2021
   Declared closed by the arbitrator on 07/06/2021

   Abraham Meir from Samandarov & Associates, P.C. participated in person for the Applicant

   Luke Harkins from James F. Butler & Associates participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 3,748.75**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant amended the amount in dispute from the original amount of $3,748.75 to $3,286.86.

   Stipulations WERE made by the parties regarding the issues to be determined.

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

3. Summary of Issues in Dispute

The record reveals that Assignor-M.C., a 30-year-old female, claimed injuries as a bicyclist involved in a motor vehicle accident that occurred on 9/4/2019. Applicant seeks reimbursement for the facility fees for left shoulder arthroscopic surgery and an anesthetic injection under ultrasonic guidance performed on 12/27/2019. Respondent partially denied the claim based on the bills exceeded the applicable Fee Schedule. The issue to be determined is whether Respondent properly partially denied payment of the services based on the applicable Fee Schedule?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement for the facility fees for left shoulder arthroscopic surgery and an anesthetic injection under ultrasonic guidance. 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 at the hearing held via Zoom. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

11 NYCRR 65-4.5 (o) (1) (Regulation 68-D), reads as follows: The arbitrator shall be the judge of the relevance and materiality of the evidence offered and strict conformity to legal rules of evidence shall not be necessary. The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations.

FEE SCHEDULE

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).

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

ANALYSIS

Applicant billed for the facility fee for left shoulder surgery under CPT codes 29823, 29825, 29821, 29999, and 29999. Respondent paid codes 29821, 29823 and 29825 in full. Respondent denied two units of code 29999 ($1,472.45 each) stating, "There is no facility fee for a procedure code in the Ambulatory Surgical Center (ASC) fee schedule; therefore, the service is not reimbursable in accordance with NJAC 11:3-29.5", "The CPT/HCPCS procedure code billed is a possible duplicate of a procedure billed previously by the same or different provider Tax Identification Number (TIN)", "There is no facility fee for a procedure code in the Ambulatory Surgical Center (ASC) fee schedule; therefore, the service is not reimbursable in accordance with NJAC 11:3-29.5", and "The amount allowed for professional health services performed outside of New York State for a New York resident shall be the lowest of (1) the amount set forth in the New York fee schedule that has the highest applicable fee; (2) the amount charged by the provider; and (3) the prevailing fee in the geographic location of the provider. (Pursuant to 11 NYCRR 68.6(b), for a professional health service

reimbursable under section 5102(a)(1) of the Insurance Law.)" Applicant indicates that the two units of code 29999 are due and owing in the amount of $2,944.90 ($1,472.45 each).

Applicant also billed for the facility fee for an anesthetic agent under ultrasonic guidance under CPT codes 64415 and 76942-59;TC. Respondent partially paid CPT code 64415 ($517.89) and denied code 76942-59 TC ($341.96), stating, "Eligible charges for surgical procedure(s) rendered in an ambulatory surgical center (ASC) shall be calculated according to the New Jersey ASC fee schedule as listed in NJAC 11:3-29.5 Appendix, Exhibit 1", "A surgical procedure reimbursed at 100% of the eligible charge and is considered to be the primary surgical procedure", "Services reported are packaged into the Ambulatory Surgical Center fee schedule facility rate or not permitted to be reimbursed separarely", "Eligible charges for surgical procedure(s) rendered in an ambulatory surgical center (ASC) shall be calculated according to the New Jersey ASC fee schedule as listed in NJAC 11:3-29.5 Appendix, Exhibit 1", "A surgical procedure reimbursed at 100% of the eligible charge and is considered to be the primary surgical procedure", "Services reported are packaged into the Ambulatory Surgical Center fee schedule facility rate or not permitted to be reimbursed separately", and "The amount allowed for professional health services performed outside of New York State for a New York resident shall be the lowest of (1) the amount set forth in the New York fee schedule that has the highest applicable fee; (2) the amount charged by the provider; and (3) the prevailing fee in the geographic location of the provider. (Pursuant to 11 NYCRR 68.6(b), for a professional health service reimbursable under section 5102(a)(1) of the Insurance Law.)". Applicant seeks $341.96 for code 76942-59-TC.

The services in dispute were provided to a New York resident and performed in New Jersey. 11 NYCRR §68.6, effective on January 23, 2018, states:

> (b) Except as provided in subdivision (a) of this section, if a professional health service reimbursable under Insurance Law section 5102(a)(1) is performed outside this State with respect to an eligible injured person that is a resident of this State, the amount that the insurer shall reimburse for the service shall be the lowest of:
>
> (1) the amount of the fee set forth in the region of this State that has the highest applicable amount in the fee schedule for that service;
>
> (2) the amount charged by the provider; and
>
> (3) the prevailing fee in the geographic location of the provider.
>
> (c) If the jurisdiction in which the treatment is being rendered has established a fee schedule for reimbursing health services rendered in connection with claims for motor vehicle-related injuries and the fee schedule applies to the service being provided, the prevailing fee amount specified in subdivisions (a) and (b) of this section shall be the amount prescribed in that jurisdiction's fee schedule for the respective service.

The services were provided at Applicant facility in New Jersey.

For New Jersey, the New Jersey Statutes-Title 39 Motor Vehicles and Traffic Regulation-39:6a-4.6 Medical fee schedules 39:6a-4.6. Medical fee schedules, indicates that the New Jersey fee schedule is the prevailing fee. The services provided are listed in the New Jersey Physicians & ASC Facility regulationand fee schedule.

For New York, effective 10/11/15, the New York State Workers Compensation Board adopted the EAPG Methodology for Calculating Ambulatory Surgery Fee Schedules, replacing the prior Products of Ambulatory Surgery (NYPAS) methodology. Under the EAPG payment methodology, reimbursement is related to the actual services provided based on patient diagnosis and the CPT/HCPCS codes reported on the claim. The CPT/HCPCS codes are grouped into APG code groups according to the procedure and/or diagnosis. Each APG has an average weight based on the group's average cost. That figure is multiplied once by 100%. Each code is then multiplied by an established base rate by setting. The primary code is increased by a "capital add - on" and the numerical value for each code is added together.

In support of its calculation, Respondent has submitted the affidavit of Becky Lynn Neve, Certified Professional Coder (CPC), dated 9/15/2020. Ms. Neve indicates that she relies on NYS Worker' Compensation Fee Schedule, the AMA CPT Assistant, and NCCI Policy Manual, among other sources, in her 11 NYCRR §68.6 analysis.

According to Ms. Neve:

> Of note, the facility submitted two separate bills for the same surgical session. All facility charges should have been submitted on one bill.
>
> …
>
> Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by an NCCI-associated modifier that is used."
>
> The 3M Core Grouper Software utilized for calculating rates, does not review the medical documentation, and as such, will make the calculation based on what procedure codes and modifiers are entered. As indicated in the NCCI Policy Manual, medical documentation needs to be reviewed to determine appropriate use of procedure codes and modifiers.
>
> Documentation Review: Regarding the use of Modifier 59 on 29821, 29825, 29999, and 76942, per the operative report (hereinto, See Exhibit N), all services were performed on the same anatomic site at the same operative session. Based on the following guidelines, the services would need to be performed to a different anatomic region, in order to be applicable.
>
> Ms. Neve conducted a detailed EAPG analysis and determined CPT codes 29821, 29825, 29999, and 76942 are not reimbursable.

For the surgery

Total Amount Billed: $8,916.04

Total NY EAPG Amount Allowed: $3,026.24

Total NJ ASC Amount Allowed: $6,462.39

In comparing the three amounts as directed by Regulation 83, the lowest amount of the three is the NY EAPG amount of $3,026.24 according to Respondent

State Farm paid the provider $5,971.14

Ms. Neve disagrees with the Respondent's EOB and indicates only code 29823 is reimbursable.

For the anesthetic agent under ultrasonic guidance

CPT code 64415- Eligible charges for surgical procedure(s) rendered in an ambulatory surgical center (ASC) shall be calculated according to the New Jersey ASC fee schedule as listed in NJAC 11:3-29.5 appendix, Exhibit 1.

64415 is listed in the NJ ASC Fee Schedule with an ASC Fees North amount of $517.89. This is the second procedure performed at the same operative session, therefore, NJAC 11:3-29.5 (d) Outpatient surgical facility fees applies, and this services prices to $258.95 which is 50% of the listed amount.

CPT® Code 76942 CPT® code 76942 is identified in the NJ ASC Fee Schedule with a payment indicator of N1. N1 indicates an ASC packaged procedure with no separate reimbursement.

Total Amount Billed: $1,321.74

Total NY EAPG Amount Allowed according to Respondent: $1,321.74

Total NJ ASC Amount Allowed according to Respondent: $258.95

In comparing the three amounts as directed by Regulation 83, the lowest amount of the three is the NJ ASC amount of $258.95.

State Farm paid the provider $517.89

"An insurer who raises this defense will prevail if it demonstrates that it was correct in its reading of the fee schedules unless the plaintiff shows that 'an unusual procedure or

unique circumstance justifies the necessity' for a charge above the schedules fee. 11 NYCRR 68.4." Jesa Medical Supply, Ind. V. Geico Ins. Co., 2009 NY Slip Op. 29386, 25 Misc. 3d 1098, (Civ. Ct. Kings Co. 2009).

I find Respondent's calculations, based on a clear reading of the New York and New Jersey fee schedules, 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 submitted an Affirmation by Aaron J. Perretta, Esq., who is employed with Applicant's counsel, but who is also identified as a CPC. Mr. Perretta indicated the total amended amount billed: $9,258.00 ($8,916.04 for the facility fee for the surgery in addition to $341.96 for code 76942 for the ultrasound).

For the surgery Mr. Perretta indicated

> Total NY EAPG Amount Allowed: $8,916.04
>
> Mr. Perretta stated in pertinent part:
>
> …
>
> It must be noted Applicant inputted Modifier 59 into the 3M Core Grouping software for CPT Codes 29821, 29825, 29999 as billed twice and 76942, since Modifier 59 was appended to these CPT Codes as billed.
>
> 21. Modifier 59's unbundling power is supported by the Workers' Comp. Board via the EAPG. Per the "New York Implementation" presentation ("Presentation") available on the Workers' Comp. Board's website at http://www.wcb.ny.gov/content/main/hcpp/MedFeeSchedules/WC_EAPGpresentati it states on page 18 Modifier 59 "Turns off consolidation - allows separate payment. See EXHIBIT D.
>
> 22. In fact, on pages 19 and 20 of the aforementioned Presentation, an example is given where two services represented by CPT Codes 24200 and 20520 both share EAPG Group 9, and CPT Code 20520 is appended with Modifier 59. See EXHIBIT D. Please note the Presentation itself was marked with those red circles to emphasize these very same points; Applicant did not affix ANY such marking to the document. On page 20, it is clear CPT Codes 24200 and 20520 were both reimbursed because Modifier 59 was affixed beside 20520 - despite sharing the same EAPG Group - and CPT Code 20520 was reimbursed at 50% of its value. This is evident by the fact that the "Pay Percentage" column lists a "1.00" (representing 100%) in regards to CPT Code 24200, and a "0.50"

(representing 50%) in regards to 20520. Further still, it is clear that CPT Code 20520's Adjusted Weight of 1.7181 is 50% of CPT Code 24200's adjusted weight of 3.4361.

23. This 50% charge is further exemplified by the APG Provider Manual annexed hereto as EXHIBIT E, stating under the definition of Modifier 59 on page 14, "[W]hen Modifier 59 is used, the additional same APG procedures will pay at 50% of the amount paid for the first procedure." 24. As applied to the instance matter, Applicant submits that Codes 29821, 29825, 29999 as billed twice and 76942 are all properly unbundled from Code 29823 since Modifier 59 was affixed to Codes 29821, 29825, 29999 as billed twice and 76942.

…

It must be stressed the AMA's description of Modifier 59 does not automatically preclude its use if the services at issue are performed upon the same body part. And in fact, Neve cites to the same terms above, including "different procedure or surgery" and "separate incision/excision," which formulates the entire basis for Applicant to be able to use Modifier 59 in the first place. See Neve, p. 7. Further, nowhere in the AMA description does it state the use of Modifier 59 is predicated upon any other coding instrument, including the Modifier 59 Article, again to be discussed infra.

…

Applicant's bill and operative report stand for the position that its use of Modifier 59 in this instance permits Codes 29821, 29825, 29999 and 76942 to be properly coded with one another and 29823, per the AMA's descriptor of same.

Per the operative report previously uploaded to MODRIA and annexed hereto as EXHIBIT A for this arbitrator's convenience, it is clear three separate incisions were performed upon the patient at the posterior portal incision site ("A posterior portal was made for access of the scope and cannula."), anterior rotator interval portal ("At this point, an anterior rotator interval portal was developed […]") and anterior portal incision site ("Through an anterior portal (…)").

50. Furthermore, six different procedures were performed on the patient's left shoulder, as denoted under the "Operations" section of the operative report.

Total NJ ASC amount allowed according to Applicant: $12,924.79.

In comparing the three amounts as directed by Regulation 83, the lowest amount of the three is the NY EAPG amount of $8,916.04 according to Applicant.

For the anesthetic agent under ultrasonic guidance

> Total Amount Billed: $1,321.74
>
> Total NY EAPG Amount Allowed according to Applicant: $341.96
>
> Code 64415-Not Entitled to Payment Per 3M
>
> Code 76942-TC-59 Greatest-Valued Code Billed Under Procedure Code 472. Reimbursed at 100% of subtotal.
>
> In regard to Radiological Code 76942, the 3M Core Grouping Software explicitly states this lone Radiological Code - unlike the aforementioned Surgery Codes - is entitled to 100% of its EAPG value.
>
> Total NJ ASC Amount allowed according to Applicant: $258.95
>
> Mr. Perretta stated: "Please note Applicant, the 3M Core Grouping Software, and Neve all concur 1) Code 29823 is entitled to reimbursement in the amount of $3,026.24; and 2) Code 76942 is entitled to $341.95. As such, the reimbursement rates of Codes 29823 and 76942 are no longer in contention".

Accordingly, after a review of the documents contained in the ECF and in consideration of the arguments made by the parties at the hearing I am more persuaded by Respondent's arguments. I agree with Ms. Neve's analysis of Modifier 59.

Based on the NCCI Policy Manual: d) Modifier 59: "Modifier 59 is an important NCCI-associated modifier that is often used incorrectly. For the NCCI its primary purpose is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters. One function of NCCI PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are 'separate and distinct.' Modifier 59 should only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes". The CPT Manual defines modifier 59 as follows: "Modifier 59: '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. From an NCCI perspective, the definition of different anatomic sites includes different organs, different anatomic regions, or different lesions in the same organ. It does not include treatment of contiguous structures of the same organ. For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes treatment of a single anatomic site. Treatment of posterior segment structures in the ipsilateral eye constitutes treatment of a single anatomic site. Arthroscopic treatment of a shoulder injury in

adjoining areas of the ipsilateral shoulder constitutes treatment of a single anatomic site".

Based on the documentation all arthroscopic surgical services were performed on the left shoulder. This is not different anatomic sites or a different patient encounter. Therefore, the use of a Modifier 59 is not appropriate. Applicant's claim for additional reimbursement is denied.

Moreover, it should be noted New York case law states reliance on the AMA CPT Book and AMA CPT Assistant is proper when interpreting fees under the WCB Fee Schedule. *See* Matter of Global Liberty Ins. Co. v McMahon, 2019 NY Slip Op 03692.

I agree with Respondent's determination that the surgery bill (amended to $2,944.50) was reimbursable in the total amount of $3,026.24 in accordance with the New York fee schedule. As Respondent paid $5,971.14 no additional reimbursement is warranted.

I note that contrary to Applicant's CPC affidavit, the parties did not agree on reimbursement for code 76942. While Ms. Neve agreed with Mr. Perretta that the code was reimbursable in the amount of $341.96 under the New York fee schedule, the New Jersey fee schedule had a lower reimbursement in the amount of $258.95, which Ms. Neve indicated was applicable in accordance with an 11 NYCRR §68.6 analysis

I agree with Respondent's 11 NYCRR §68.6 analysis, which indicates the bill for the anesthetic injection under ultrasonic guidance is reimbursable in the amount of $258.95 in accordance with the New Jersey fee schedule as the lowest of the two fee schedules and the amount billed. As Respondent paid $517.89 no additional reimbursement is warranted.

Accordingly, Applicant's claim is denied. This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

5. Optional imposition of administrative costs on Applicant.
   Applicable for arbitration requests filed on and after March 1, 2002.

   I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**
   - ☐ The policy was not in force on the date of the accident
   - ☐ The applicant was excluded under policy conditions or exclusions
   - ☐ The applicant violated policy conditions, resulting in exclusion from coverage
   - ☐ The applicant was not an "eligible injured person"
   - ☐ The conditions for MVAIC eligibility were not met
   - ☐ The injured person was not a "qualified person" (under the MVAIC)
   - ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle

☐The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York
SS :
County of Nassau

I, 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.

08/05/2021
(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:
ee24e5c3eb64247b6870a0abd1703403

Electronically Signed

Your name: Eileen Hennessy
Signed on: 08/05/2021