

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

All City Family Healthcare Center
(Applicant)

- and -

Progressive Casualty Insurance Company
(Respondent)

AAA Case No. 17-20-1175-3769

Applicant's File No. SS-148258

Insurer's Claim File No. 20-5812355

NAIC No. 11851

ARBITRATION AWARD

I, Laura Yantsos, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD**:

Injured Person(s) hereinafter referred to as: Assignor

1. Hearing(s) held on 08/16/2021
Declared closed by the arbitrator on 08/31/2021

Sabine Sciarrotto, Esq. , from Samandarov & Associates, P.C. participated in person for the Applicant

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

2. The amount claimed in the Arbitration Request, **\$ 9,863.07**, was NOT AMENDED at the oral hearing.
Stipulations WERE NOT made by the parties regarding the issues to be determined.
3. Summary of Issues in Dispute

Can the Respondent's reduction of the charges be sustained under the governing fee schedules?

4. Findings, Conclusions, and Basis Therefor

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The claim is for the balance due for facility charges during shoulder arthroscopy, specifically for \$5,677.77 for Code 29821, \$1,472.45 codes 29823 billed with modifier 59, for \$1,472.45 for Code 29825 billed with Modifier 59, \$1,472.45 for Code 29999 billed with Modifier 59, and \$1,472.45 for Code 29999 billed with modifier 59. In addition, in a separate billing, the Applicant billed \$979.78 under Code 64415 (withdrawn at the hearing), and billed \$341.96 under code 76942. The total amount of the claim is in the sum of \$8,883.29.

The Respondent determined that Code 29823 was the primary procedure and paid the Applicant the sum of \$3,026.24, twice the amount charged by the Applicant and denied all other codes on the grounds the billing was in excess of maximum allowable charges under the governing EAPG fee schedule.

The Applicant submitted its rebuttal affidavit in an untimely manner, and therefore Respondent was granted an extension of time to submit an addendum reply, which was submitted. The Applicant moved for an extension of time to submit a sur-reply to the rebuttal, which was denied. The burden of proof on the issue of fee schedule rests with the Respondent who shall have the last word.

The dispute concerns the Respondent's transition of Code 29823 as the primary surgical service (rather than Code 29821) and Respondent's denial of codes billed with Modifier 59. With regard to the procedures performed and billed with Modifier 59, the following issues are in dispute.

It is the Applicant's position that when Modifier 59 is utilized, and accepted into the 3M computer software EAPG system with the billing, payment must be allowed. Further, Applicant states that the NCCI Edits are not authoritative or to be followed in Worker's Compensation. The Applicant states that if the programed computer software accepts the billing utilizing Modifier 59, that will ipso facto, authorize the use of Modifier 59, for when it is not authorized, the 3M computer program will not accept the billing. He further states that even under the Edits, his charges warrant a Modifier 59 billing as there was a separate incision and *separate and distinct* procedures performed at the time of the surgery as defined by the governing Edits. Lastly, Applicant takes the position that Code 29821 was the primary and most extensive procedure performed, and should have been paid at a different rate.

The Respondent coder shows that despite the acceptance by the 3M software of Modifier 59, the NCCI Edits are authoritative as set forth in "Health Care Information - Worker's Compensation Enhanced Ambulatory Patient Group - FAQ #22" which specifically refers the user to the provider manuals of Medicaid, found on the CMS Website. <http://www.wcb.ny.gov/content/main/hcpp/EAPG.jsp#ambulatory> and http://www.wcb.ny.gov/content/main/hcpp/MedFeeSchedules/WC_EAPGpresentation201 (See page 6)

Respondent shows persuasively that the NCCI edits are to be utilized in determining whether Modifier 59 may be used even when the computer software accepts the billing utilizing Modifier 59. That the function of the Edits is to prevent payment for codes that

report overlapping services except in those instances where the services are "separate and distinct" as defined by relevant guides.

The Edits therefore override the software's acceptance of Modifier 59 on this billing and the documentation must otherwise support the billing of Modifier 59. The Respondent shows through the Edits and the examples given in the guide, that the codes used, which have the same EAPG score, does not fall under any exception found in the Edits for utilizing Modifier 59. The fact that more than one incision was made, as is common during arthroscopic procedures, would not allow for use of Modifier 59. Nor may the procedures be construed as separate and distinct as it concerns facility charges.

The CPT Manual defines Modifier 59 as follows:

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.**

The controlling words are not only that there must be a different procedure or surgery or different site or organ system, or a separate incision/excision, etc. but that these different procedures, sites or organ systems, or separate incisions that **"are not ordinarily encountered or performed on the same day by the same individual", i.e. that they are ordinarily encountered on a different day.**

The NCCI Edits, adopted by Medicare and Medicaid and used in Worker's Compensation as above described, , limits the use of Modifier 59 when applied in the context of Arthroscopy of the shoulder.. "CMS considers the shoulder to be a single anatomic structure." "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 of the same organ or anatomic region does NOT constitute treatment of different anatomic sites. For example.....arthroscopic treatment of structures in adjoining areas of the same shoulder constitute treatment of a single anatomic site."(emphasis supplied). See Center for Medicare and Medicaid Services (CMS) Modifier 59 Article

Respondent points out that the guide shows that there are three exceptions in which Modifier 59 may not be billed: With three exceptions, shoulder arthroscopy procedures include extensive debridement (CPT code 29823), even if the extensive debridement is performed in a different area of the same shoulder than the other procedure billed and paid for. CPT Code 29824 (arthroscopic claviclectomy including distal articular surface), Code 29827 (arthroscopic rotator cuff repair) and 29828 (biceps tenodesis) may be reported separately with CPT Code 29823 if the extensive debridement is performed in a difference area of the same shoulder.

Codes 29823 was not billed along with 29824, 29827 or 29828, and therefore the modifier was improper. Code 29823 is considered the more extensive procedure as of

amendments made effective 12/31/16 and therefore, the allowable primary code. According to the Edit Table, Code 29821 would not be considered the primary procedure regardless of the APG weighted amount. Code 29823 would be the primary procedure over 29821.

The Respondent's coder, who has worked with the New York State Worker's Compensation Fee Schedule and New Jersey Regulation for over 20 years. She is a certified Professional Coder credentialed by the American Academy of Professional Coders since 2004. . Her certification is physician based, focusing on physician and other qualified health care providers in the office or facility setting. Her education and training and experience is vast. She is trained to interpret a patient's medical chart and assign the correct diagnosis, procedure and supply code to the service provided by a physician or qualified health care provider. Her credentials are impeccable. Her explanations are coherent and persuasive. There is little doubt that in the governing fee schedules, she is well trained.

With regard to the second bill, the Applicant billed the carrier with two separate bills for facility charges, despite the fact that the services were performed during the same surgical session. One bill was for an anesthetic procedure and the other for anesthesia and ultrasound utilized and the other for the arthroscopic services.

Pursuant to the Policy and Billing Guidance Ambulatory Patient Groups Provider Manual, Section 3.5 use of Visit and Episode Rate Codes "...All services and procedures provided to a patient with the same date of service and rate code (based on servicing provider type-i.e. OPD, Ambulatory Surgery Center, ED and D&TC)...must be billed together on one claim. If two claims are submitted for the same patient with the same rate code, same date of service and the same provider (hospital or D&TC)...only the first claim will result in payment. The second claim will be denied. The claims on the second billing are denied

The Respondent coder raises some salient underlying considerations in determining facility charges under the EAPG schedules. The Respondent coder points out that while multiple procedures were performed by a surgeon during the same session, which may be billed separately by the surgeon, each may not be billed separately as a facility fee. The multiple procedures that may be billed by the facility is not for the performance of surgical procedures, but for the rental time of a surgical room in an ambulatory surgical center, and the EAPG fee schedule and guides governing facilities would not be identical to surgeon's charges. Respondent shows that various procedures conducted during the same session may not be charged by the facility (as they may by the surgeon) unless the documentation shows they fall within the limited exceptions set forth in the authoritative guides.

The claim is denied in its entirety.

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 Suffolk

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

09/29/2021
(Dated)

Laura Yantsos

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:
270473e4c0f16e2f24db610cd448b4c5

Electronically Signed

Your name: Laura Yantsos
Signed on: 09/29/2021