

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

New Horizon Surgical Center LLC  
(Applicant)

- and -

Progressive Casualty Insurance Company  
(Respondent)

AAA Case No. 17-20-1175-3706

Applicant's File No. SS-146870

Insurer's Claim File No. 19-3158164

NAIC No. 11851

**ARBITRATION AWARD**

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

Injured Person(s) hereinafter referred to as: Assignor

1. Hearing(s) held on 08/19/2021  
Declared closed by the arbitrator on 09/06/2021

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

Lance Faustin from Progressive Casualty Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 6,950.49**, was NOT AMENDED at the oral hearing.  
Stipulations WERE NOT made by the parties regarding the issues to be determined.
3. Summary of Issues in Dispute

The Assignor, AS, is a 33yo male who was injured in a motor vehicle accident on 8/25/19. AS suffered injuries which resulted in his seeking treatment. In dispute is the Applicant's facility claim for left knee arthroscopic surgery performed on 11/5/19 in the total amount of \$11,567.57. Respondent partially paid the claim in the amount of \$5,677.77, leaving an amount in dispute of \$5,889.80 based on a fee schedule defense.

Also in dispute is Applicant's claim for a nerve block injection with echo guide performed on 11/5/19 in the total amount of \$1,171.26. Respondent partially paid the claim in the amount of \$110.57 leaving an amount in dispute of \$1,060.69 based on a fee schedule defense. Therefore, the issue in dispute is if Respondent can sustain its fee schedule defenses.

#### 4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the Parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived. Both parties were allowed to submit additional fee schedule documents in a post-hearing submission due by 9/3/21. Both parties submitted their post-hearing submissions and the hearing was closed

Respondent partially paid Applicant's claims in the amounts of \$5677.77 and \$110.57, leaving amounts in dispute of \$5,889.80 and \$1,060.69, based on a fee schedule defense.

If Respondent fails to demonstrate by competent evidentiary proof that an Applicant's claims were in excess of the appropriate fee schedule, Respondent's defense of noncompliance with the appropriate fee schedule cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y.Misc. LEXIS 1109 (App. Term, 1<sup>st</sup> Dep't, per curiam, 2006).

The primary issue in dispute is whether or not modifier 59 was properly applied to the CPT codes. Respondent submits a fee coder affidavit by Karen McCauley, CPC, dated 8/19/20 in which Ms. McCauley opines that CPT codes 298881, 29875, 2987976 and G0289 do not meet criteria for qualified payable exceptions as the surgery was at the same anatomic site in the same patient encounter and that therefore modifier -59 is not appropriate. She concludes that based on her EAPG analysis the total allowed amount for the two claims is \$5,677.77 and therefore, since Respondent previously paid an additional \$110.57, that no further payment is due.

Applicant responds with an unsigned fee coder affidavit by Aaron J. Perretta, Esq., CPC, dated 8/18/21, in which the affiant opines that Ms. McCauley has failed to meet Respondent's burden.

Respondent submits an addendum report by Ms. McCauley and Applicant submits an IHC report by Joyce Ehrlich in support of its EAPG modifier 59 analysis. However, it is unclear from that IHC report if it was made with the benefit of competing fee coder reports as is presented in this hearing.

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

*...Joyce Ehrlich, a Certified Professional Medical Auditor issued an opinion after reviewing the claim, operating report and medical record, both fee coder affidavits, and*

*the fee schedule. Ms. Ehrlich stated that "I arrived at the EAPG amount using the DOH rate files available to perform this function manually." She noted that "the EAPG computation may be performed manually and the 3M product is not absolutely required to make the necessary calculations." Regarding modifier 59, she stated,*

*"justifying the use of modifier 59 based [on] separate incisions which are inherent to the procedure during the same operative session, on the same site, and not considered a distinct or independent procedure, is incorrectly interpreting the AMA CPT manual definition of modifier 59."*

*She stated that the AMA CPT manual defines modifier 59 as follows, "documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury . . . not ordinarily encountered or performed on the same day by the same individual." She stated that the use of modifier 59 in the case of arthroscopic surgery is incorrect unless certain circumstances exist which must be documented in the medical record. She noted that from an NCCI perspective, "the definition of different anatomic sites includes different organs, or in certain instances different lesions in the same organ . . . however, NCCI edits are typically created to prevent the inappropriate billing of lesions and sites that should not be considered to be separate and distinct," She stated that modifier 59 "should only be used to identify clearly independent services that represent significant departures from the usual situations described by the NCCI edit, and "the treatment of contiguous structures in the same organ or anatomic region does not constitute treatment of different anatomic sites." She noted that arthroscopic treatment of structures in adjoining areas of the same shoulder constitutes treatment of a single anatomic site.*

*Regarding Ms. Prajapati's statement regarding the use of Modifier 59, she stated that, "since the shoulder is composed of three compartments, it would not be medically feasible to perform the arthroscopy properly without creating multiple incisions to gain access." She noted that the "incisions were made to complete procedures which are not reimbursed separately." She also noted that the 3M Software interprets what has been entered into the system and does not have the ability to*

*review the operative report, know where the incisions were made, or whether the documentation supports modifier 59. She stated that, "applying NCCI edits and CPT guidance in this case, provides more accurate guidance." She also stated that Ms. Prajapati was incorrect to state that EAPG group 37 is not subject to consolidation. She stated that Ms. Prajapati referred to EAPG "types", not EAPG groups, and she failed to correctly interpret the FAQs she cited. Finally, she noted that "if the physician performs both procedures on the right shoulder and bills the procedures together they are considered bundled services and as such only CPT 29823 will be reimbursed. Similarly to the Respondent's fee coder, she noted that based on the documentation, CPT code 29821, 29825, and 29819 would not be separately reimbursed. She agreed with Respondent that the total reimbursement for CPT 29823 should be \$3026.24.*

*Regarding CPT 64415, she noted that the patient did not receive general anesthesia but intravenous anesthesia and a regional block, to improve the post-operative recovery. She stated that NCCI guidelines state that certain post-operative pain management procedures may only be separately reportable with anesthesia "if the mode of the anesthesia is general." She noted that in this case the Assignor did not receive general anesthesia but rather intravenous anesthesia and a "block." She stated that CPT 64415 is a Column 2 code for CPT 29823 and they cannot be reported together even with a modifier based on the NCCI edits.*

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

*In this case, I find the IHC report was thorough and persuasive. As described above, the IHC report was detailed, reviewed and evaluated both parties' affidavits, and cited to numerous sources. The IHC report was consistent with Respondent's fee coder affidavit with regard to CPT codes 29821, 29825, 29819, and 29823, as well as CPT code 64415. The IHC report explained that the 3M software, which Applicant relied upon, could be helpful, but that in this case, manual computation was more accurate. Both the Respondent's affidavit and the IHC report cited to the NCCI edits, which indicated that consolidated modifier 59 was not supported in this case.*

*The IHC report referred directly to the medical reports regarding the shoulder arthroscopy, and explained that modifier 59 was not supported in this case even though multiple incisions were made. The IHC report also explained the appropriate billing for CPT 64415, which was not general anesthesia, but a block to improve post-operative recovery. The IHC report directly addressed Ms. Prajapati's affidavit and explained why her interpretation was incorrect. With regard to CPT 76942, the IHC report persuasively explained that it is reimbursed separately, consistent with and in accordance with Applicant's billing.*

Based on the reasoning presented in the IHC report discussed in Arbitrator Mir's award I find the opinion as set forth by Ms. McCauley regarding the amount due for the arthroscopic surgery persuasive and that Applicant was already reimbursed the maximum amount due. However, I find that also based on the reasoning presented in the IHC report that Applicant is due separate reimbursement for CPT code 76942 in the amount of \$341.96. As Respondent previously partially paid the claim in the amount of \$110.57, Applicant is awarded the balance of \$231.39.

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
	New Horizon Surgical Center LLC	11/05/19 - 11/05/19	\$5,889.80	Denied
	New Horizon Surgical Center LLC	11/05/19 - 11/05/19	\$1,060.69	Awarded: \$231.39
Total			\$6,950.49	Awarded: \$231.39

- B. The insurer shall also compute and pay the applicant interest set forth below. 08/13/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

In the instant matter Applicant is awarded interest pursuant to the no-fault regulations. 11 NYCRR 65-3.9 (a) provides that Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." Pursuant to 11 NYCRR 65-3.9 (c), "if an applicant does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Department of Financial Services regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken." Applicant electronically submitted its claim for arbitration on 8/13/20, more than thirty days after receipt of the denial of claims. Therefore, interest shall run effective 8/13/20.

C. Attorney's Fees

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

An attorney's fee of 20% shall be paid on the sum of the awarded claim plus interest, subject to a maximum of \$1,360.00.

- D. The respondent shall also pay the applicant forty dollars (\$40) to reimburse the applicant for the fee paid to the Designated Organization, unless the fee was previously returned pursuant to an earlier award.

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

State of New York  
SS :  
County of Nassau

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

10/05/2021  
(Dated)

Kevin R. Glynn

### **IMPORTANT NOTICE**

*This award is payable within 30 calendar days of the date of transmittal of award to parties.*

*This award is final and binding unless modified or vacated by a master arbitrator. Insurance Department Regulation No. 68 (11 NYCRR 65-4.10) contains time limits and grounds upon which this award may be appealed to a master arbitrator. An appeal to a master arbitrator must be made within 21 days after the mailing of this award. All insurers have copies of the regulation. Applicants may obtain a copy from the Insurance Department.*

## **ELECTRONIC SIGNATURE**

**Document Name:** Final Award Form  
**Unique Modria Document ID:**  
aeb6360c966cc91db7bf35926265f5a1

### **Electronically Signed**

Your name: Kevin R. Glynn  
Signed on: 10/05/2021