American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

NYEEQASC, LLC d/b/a North Queens Surgical Center (Applicant)	AAA Case No.	17-21-1204-6749
	Applicant's File No.	NA
- and -	Insurer's Claim File No.	20-6500927
	NAIC No.	24260
Progressive Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, John O'Grady, 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 10/04/2021
   Declared closed by the arbitrator on 10/04/2021

   Nataliya Borushchak Esq. from Roytblat Law Group, PLLC participated in person for the Applicant

   Jean Schabuttl, a claims representative from Progressive Casualty Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 5,642.39**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   Unless otherwise indicated in Section 3 below, in which case the dispute between the parties will be addressed in this Award, the parties stipulated and agreed that (i) Applicant has met its prima facie burden by submitting evidence that payment of no-fault benefits are overdue, and proof of its claim was mailed to and received by Respondent; (ii) Respondent's denial of the subject claim was timely issued; and (iii) the amount claimed does not exceed the maximum permissible charges under the fee schedule applicable to the disputed services.

3. Summary of Issues in Dispute

CASE SUMMARY

Applicant, as assignee of an eligible injured person, a 50-year-old male, seeks reimbursement of the following charge(s) following a motor vehicle accident on June 29, 2020: the facility fee for an injection with anesthetic agent and ultrasonic guidance for needle placement along with a shoulder arthroscopy with rotator cuff repair, synovectomy and debridement as well as surgical supplies, all performed on October 5, 2020.

Respondent timely denied the claim(s), paying it in part and denying it in part contending that it made proper payment pursuant to the Workers Compensation Fee Schedule.

ISSUE(S)

Whether respondent properly paid the claims consistent with the applicable Fee Schedules.

4. Findings, Conclusions, and Basis Therefor

Applicant made its claims on two bills. On one it made the following claims in the following amounts:

1. CPT 64415 RT-Injection(s), anesthetic agent(s) and/or steroid; brachial plexus; $979.78; and

CPT 76942 59 TC-Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation; $341.96

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

Respondent also added that: Pursuant to the 33rd amendment to Regulation 83, we have reviewed your services at the fee set forth in the region of NY that has the highest amount in the fee schedule for that service;

On a second it made the following claims in the following amounts:

2. 29827 RT-Arthroscopy, shoulder, surgical; with rotator cuff repair; $5677.77;

29821 59 RT-Arthroscopy, shoulder, surgical; synovectomy, complete; $2798.20;

29823 59 RT-Arthroscopy, shoulder, surgical; debridement, extensive; $1472.45;

A4649 -Surgical supply; miscellaneous; $50.00.

Respondent paid the claim pursuant to CPT Code 29827 in the amount of $5677.77 and denied the remaining three claims explaining that:

For CPT Code 29821-This service is identified as an integral part of a medical visit and is associated with professional services and does not warrant a separate reimbursement.

For CPT Code 298-212-9823-Pursuant to the NYS APG Manual, "Grouping Elements of the APG Payment System": multiple related significant procedure APGs are consolidated into a single APG for the purpose of determining payment. "CPT Modifier 59 should be used to designate instances when distinct and separate multiple services with the same APG are provided to the patient on a single date of service (eg. separate encounters, different surgeries, different sites or organ systems, separate incisions)." NY EAPG methodology for reimbursement of ambulatory surgery facility services includes the Hospital Outpatient NCCI edits and Medical Unlikely edits. Services identified in the NCCI edits as an integral component of the significant procedure performed do not warrant separate reimbursement. Documentation submitted supports that the use of Modifier 59 is inappropriate in this instance. Billing has been consolidated into a single APG for reimbursement, which has been paid accordingly.

For CPT Code 29823-Significant procedure Consolidation (refers to the collapsing of multiple related significant procedure APG's into a single EAPG for the purpose of determining payment) based on the New York Enhanced Ambulatory Patient Grouping (EAPG) Methodology.

For CPT Code A4649-This charge has been evaluated as a Never Pay service using the procedure guidelines from the New York Enhanced Ambulatory Patient Grouping (EAPG) methodology.

Respondent supports its defense with the affidavit of its employee, Lori Curtin, a Certified Professional Coder. She explains that:

The Official New York State Workers' Compensation Fee Schedule instructions and ground rules explain the application of the procedure descriptors and relative value units. When greater explanation or an instruction or ground rule is needed, the Fee Schedule directs a coder to refer to the Current Procedural Terminology Book ("CPT book") which is written by the AMA.

The CPT book is a listing of descriptive terms and identifying codes for reporting medical services and procedures provided to patients. The CPT book provider's further explanation of descriptive terms and identifying codes. When more clarification is needed the CPT book directs a coder to the Current Procedural Terminology Assistant (CPT Assistant) which is also authored by the AMA. The CPT Assistant provides even greater clarity than the CPT book on specific coding issues.

Applicant submitted two claims for medical services allegedly rendered on October 5, 2020. The surgical codes billed on the first claim were 29827; 29821-59; 29823-59 and A4649 - the provider billed a total of $9,998.42 for this bill. The second claim was for a Nerve Block with Ultra-Sound Guidance in the same region and used CPT Codes 64415 and 76942 -TC-59 the provider billed a total of $1,321.74 for this bill. Copies of the claims form and supporting documentation are attached at Exhibit "1".

Effective October 1, 2015, the New Enhanced Ambulatory Payment Groups ("EAPG") Fee Schedule applied to Ambulatory Surgical Centers and hospitals. Pursuant to 12 NYCRR 329-2.1 "Payment for ambulatory surgery services shall be made according to the ambulatory patient groups (AFG) methodology, governing reimbursement for licenses freestanding ambulatory surgical centers and hospital-based ambulatory surgery services as set forth herein and subject to Workers' Compensation Board specific adjustments." Attached at Exhibits "2" and "3" are copies of the Workers' Compensation Board memo Subject Number 046-784 discussing the change and Implementation Guide discussing the application of the AFG methodology.

The NY EAPG - Overview of Key Websites/Resources provides greater guidance on the factors considered by 3M Grouper Software as well as guidance on the manual calculation of EAPG rates. Progressive has elected to manually calculate the EAPG adjustments for the services in dispute.

Review of the records submitted in support of the claim demonstrate the Applicant is only entitled to $5,677.77.

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

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

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

The National Correct Coding Initiative Edits (NCCI Edits), adopted by the Medicare and Medicaid, limits the use of modifier -59 when applied in the context of Arthroscopy. Chapter IV, Surgery: Musculoskeletal System, CIT Codes 20000-29999. Section E (4) reads in part, "... CMS considers the shoulder to be a single anatomic structure. With three exceptions an NCCI procedure-to-procedure edit code pair consisting of two codes describing two shoulder arthroscopy procedures shall not be bypassed with an NCCI-associated modifier when two procedures are performed on the ipsilateral

shoulder. This type of edit may be bypassed with an NCCI-associated modifier only if the two procedures are performed on contralateral shoulders. The three exceptions are described in chapter IV, Section E (Arthroscopy), Subsection #7' Copies of relevant sections of the NCCI General Rules and Guidelines are attached at Exhibit "5".

Based on the documentation submitted, CIT codes 29827, 29821 and 29823 do not meet the criteria for qualified payable exceptions; modifier -59 is not appropriate on code 29821 or 29823.

As set forth in the implementation guide, "... Significant procedure consolidation refers to the collapsing of multiple related significant procedure APGs into a single AFG for the purpose of determining payment....". Review of the EAPG Schedules in the 3M AFG Crosswalk database assigns CIT Codes 29827 and 29821 to AFG 38 and CIT Code 29823 to AFG 37. The application of the predetermined weight, discounts, rate, and capital add on result in CIT Code 29827 being compensated in the amount of $5,677.77. Code A4649 is assigned to AFG 1001; this AFG has a pre-determined weight of '0.'

Pursuant to the Policy and Billing Guidance Ambulatory Patient Groups Provider Manual, Section 3.5 use of Visit and Episode Rate Codes " . .. Importantly, she explains that: 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. If a patient returns to the clinic for multiple visits on the same date of service, all the procedures must be billed on one claim with the appropriate AFG rate code... if the provider attempts to submit multiple AFG claims for that rate code for the same recipient/same date of service, only one claim will be paid. All others will be denied as duplicative claims... " Application of the guidelines eliminates the claim for the Nerve Block (CIT code 64415) with Ultra-Sound Guidance (CIT code 76942); further NCCI Guidelines concerning CIT Codes 60000-69999 note"...the physician shall not report CIT Codes 64400-64530 for anesthesia for a procedure. Here the major procedure is the Arthroscopy performed on the same date of service. Copies of the relevant section of the NCCI guidelines are attached at Exhibit "8" and "9". (Emphasis added)

Since the provider billed improperly - according to the Provider Manual guidelines - by not submitting all charges for the same date of service on the same bill, the second bill was denied. She concludes that the applicant is only entitled to $5,677.77 and the remainder of the claim should be dismissed as billed in excess of the Worker's Compensation Fee Schedule pursuant to 11 NYCRR 65-3.8 (g)(l)(ii) and 11 NYCRR 68.7.

In assessing this issue, I am persuaded by Respondent's contention regarding modifier 59 being inappropriate for these codes because all the procedures were performed on the same shoulder. This position is supported by the NCCI Policy Manuals. I find the NCCI Policy Manual issued by the Centers for Medicare & Medicaid services (CMS) to be instructive in evaluating this issue. This manual provides guidance on how NCCI edits are to be used, and when it would be appropriate to suppress the NCCI edits. With the

3M software using NCCI edits developed by CMS, I find no reason why it would be improper to use the CMS issued NCCI Policy Manual as guidance to determine when modifier 59 would be appropriate to suppress the NCCI edits. Proof that the 3M software uses NCCI edits to render its calculation can be found in [1] the Workers' Compensation Enhanced Ambulatory Patient Group (EAPG) - Ambulatory Surgery Fee Schedule FAQs - Question 7, [2] the November 2015 3M presentation on New York Implementation (3M Enhanced Ambulatory Patient Groupings) and [3] TM Applicant's 3M worksheet under the "Edits" section in its analysis for CPT 29823, 29825, 29821, and 29826. Copies of the NCCI Policy Manuals are publicly available at the CMS official website located at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Manual-Archive In this case, the 2019 NCCI Policy Manual support Respondent's contention that modifier 59 was inappropriate since all procedures were performed on the same shoulder.

2019 NCCI Policy Manual, Chapter IV, Section E (Arthroscopy), Subsection #4 states the following: "CMS considers the shall not 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 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." (emphasis added). The three exceptions listed in Chapter IV, Section E (Arthroscopy), Subsection #7 are as follows: "With three exceptions, shoulder arthroscopy procedures include extensive debridement (e.g., CPT code 29823) even if the extensive debridement is performed in a different area of the same shoulder than the other procedure. CPT codes 29824 (arthroscopic claviculectomy including distal articular surface), 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 different area of the same shoulder."

In this case, the policy manual clearly states that the shoulder arthroscopy procedure already includes CPT 29823. As to CPT code, 29821, it is not listed as an exception and were all performed on the same shoulder, the right shoulder. As such, Respondent was correct in determining the use of modifier 59 to be inappropriate.

Therefore, I find that Respondent sufficiently met its initial burden in substantiating its fee schedule defense. In this case, the alleged different procedures were all performed on the same shoulder during the same patient encounter rendering modifier 59 inappropriate. This analysis is congruent with the analyses by IHCs regarding the same issue found in the following awards: Arbitrator Ann Lorraine Russo, Surgicore Surgical Center LLC v. State Farm, (4/22/2020), Arbitrator Victor Moritz, AAA#: 17-19-1116-2108 Fifth Avenue Surgery Center LLC v. Allstate , AAA#: 17-18-1113-9435 (3/23/2020), and Arbitrator Ann Lorraine Russo, Fifth Avenue AAA#: Surgery Center LLC v. National General Insurance Online, Inc., 17-18-1091-0535

(8/30/2019). In weighing all the arguments and evidence, I am persuaded by Respondent's contention that it was inappropriate to use modifier 59 for CPT 29821 and 29823. As such, I find these codes to not be reimbursable.

As Ms. Curtin adequately explains why all claims should be made on one bill and that, therefore, the claims pursuant to CPT Code 64415 and 76942 for the injection and ultrasonic guidance are not compensable, that portion of the claim is also not reimbursable. For these reasons, the claim is denied.

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

10/06/2021
(Dated)

John O'Grady

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:
ad336e0f9807a9235a34fb5a8103e3a3

Electronically Signed

Your name: John O'Grady
Signed on: 10/06/2021