

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Rockaways ASC Development LLC d/b/a
ASC of Rockaway Beach
(Applicant)

- and -

Progressive Casualty Insurance Company
(Respondent)

AAA Case No.	17-22-1257-7211
Applicant's File No.	none
Insurer's Claim File No.	21-2550474
NAIC No.	24260

ARBITRATION AWARD

I, Maryann Mirabelli, 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 05/09/2023
Declared closed by the arbitrator on 06/03/2023

Robert Cipitelli, Esq., from Jakubowitz Law Firm PC participated virtually for the Applicant

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

2. The amount claimed in the Arbitration Request, **\$9,629.95**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant reduced the amount in dispute as it acknowledged a partial payment and amended pursuant to its interpretation of the fee schedule. Specifically, Applicant acknowledged CPT Code 63075 was paid properly. Respondent conceded CPT Code 63076 -59 in the amount of \$2605.78. At issue remains CPT Code 22526 and 22527 both billed with Modifier 59 and for which the Applicant contends an additional \$2605.70 per code is due and owed for a total, including the concession of \$7817.34.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The arbitration arises out of a motor vehicle accident which took place on 6/23/21 whereby the Assignor (WS) a then 58-year-old male was injured in the accident and sought treatment with the provider. Applicant is seeking reimbursement in the amount of \$7817.34 for the balance of the facility fee associated with a spine surgery performed on 9/19/21, along with interest and counsel fees, under the No-Fault Regulations in connection with injuries sustained in the motor vehicle accident.

The threshold issue presented at the hearing is whether Respondent's fee schedule defense can be sustained.

4. Findings, Conclusions, and Basis Therefor

The hearing proceeded by ZOOM.

This decision is based upon the written submissions of counsel for the respective parties as well as oral argument. I have reviewed the documents contained in the Record as of the date of the hearing.

Pursuant to 11 NYCRR 65-4 (Regulation 68-D), §65-4.5, an Arbitrator shall be the judge of the relevance and materiality of the evidence offered...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. Master Arbitrator Peter J. Merani, in the case of Sports Medicine & Orthopedic Rehabilitation a/a/o "I.B." v. Country-Wide Insurance Co., AAA Case No. 17-R-991-14272-3, stated, in relevant part, that "*the Arbitrator below is the trier of facts and must evaluate and weigh the evidence presented at the hearing in arrive at [his/her] decision. The Arbitrator, in weighing the evidence, has broad powers and discretion in determining what evidence is relevant and material. The Arbitrator is in the best position to evaluate the evidence and decide on the credibility of the submitted documents*".

Upon reviewing the evidence submitted by the Applicant, I find the Applicant submitted sufficient credible evidence to establish a prima facie case with the respect to the services that are the subject of this arbitration. See, Mary Immaculate Hospital v. Allstate Insurance Co., 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004) Once Applicant has made out a prima facie case, the burden shifts to Respondent to timely request additional verification, deny, or pay the claim. Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co., 9 NY3d 312 (2007). Respondent paid a portion of the claim, leaving a balance of \$9,629.95. At the hearing, Applicant amended the amount in dispute to \$7817.34 of which Respondent concedes \$2605.78 is due and owed to the provider for CPT code 63076 billed with modifier 59 as per their Coder Affidavit. However, it maintains the remainder should be denied.

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). 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.2d 558 (App. Term 2d, 11th & 13th Dists. 2009). I may also take judicial notice of the fee schedule. See Kingsbrook Jewish Medical Center the Allstate Insurance Company, 61 AD 3d 13 (2d Dept. 2009).

Respondent submitted an affidavit by a certified professional coder, ("CPC"), Sarah Harder to support the partial payment, the concession and the argument that CPT Code 22526 and 22527 are not reimbursable. In response, Applicant has submitted an affidavit by Roza Vinogradov who attests that the two codes at issue are allowed to be billed with modifiers as the procedures performed are *"different surgery types on different parts of 2 different discs at different sites (levels) targeting different body systems (neurological and musculoskeletal)." Applicant maintains the procedures support the modifiers.*

This Arbitrator sent this fee schedule issue to an Independent Health Consultant ("IHC") for review. A review by Joyce Ehrlich, MS, MPA, CPMA, CPCO, CEMA, CPB was reviewed which details the documents she reviewed including the operative report, NF-10, UB-04 claim for services medical records, affidavit of Sarah Harder and affidavit from Roza Vinogradov. She indicates the authorities used included AMA CPT book, AMA CPT Assistant, AMA CPT Changes, an insider's view, NCCI Policy Manual for Medicare Services, EAPG Provider Manual, and the NCCI PTP Edits in addition to the New York Workers Compensation EAPG fee scheduled.

Ms. Ehrlich sets forth a detailed breakdown of each CPT code and finds the following,

"I have reviewed the Affidavits provided on behalf of the Applicant and Respondent. I agree with Reviewer Vinogradov who states that CPT 22526-59 and CPT 22527 should be reimbursed separately. She further states that there are no NCCI edits precluding the billing of for the discectomy and annuloplasty separately. I disagree with Reviewer Harder, who states that CPT 22526 and CPT 22527 should not be reimbursed separately and are consolidated into CPT 63075. These codes are not subject to consolidation but are subject to discounting.

Reviewer Harder states that Modifier -59 should not be used on CPT codes 22526, 22527, 62291, and 72285. She states that these procedures were performed at the same anatomic site and same patient encounter. I disagree with this since, modifier -59 should be appended to CPT 22526 since this indicates that a separate procedure (annuloplasty) was performed during the same date of service as the discectomy. (see reference C. above). I do agree that modifier -59 should not be appended to CPT 22527 since this is an add-on code."

The footnote section clearly indicates:

- *Add-on codes (CPT 63076 and 22527) do not require a modifier -59 as they cannot be billed independently of the primary code (CPT 63075 and 22526). Modifier -59 is correct on CPT 22526, as this indicates a separate procedure.*
- *These codes are subject to discounting and are therefore reimbursed at 50% the value of the primary procedure.*
- *Procedure code is not payable in APGs but is available for billing on ordered ambulatory fee schedule. Procedure codes listed as carve outs should not be billed using APGs. Indication as a carve out does not guarantee alternative payment.*

She confirmed via email through the American Arbitration Association that as part of her initial report, she read and considered all the documents, including the Respondent's addendum and she does not agree that there is no reimbursement for CPT Code 22526 and 22527. As mentioned in her report, modifier -59 should not be appended to CPT 22527 since this is an add-on code which cannot be billed without the primary code. Hence, no -59 is necessary. The IHC states CPT 22526 and 22527 were done at the same level as CPT 63075 and 63076, they should not be paid separately. There are no NCCI edits or guidelines that prevent the billing of these two procedures together and them being paid separately. The -59 appended to CPT 22526 is correct since it indicates a separate procedure performed on the same date of service as another procedure.

In response to the IHC, Respondent submitted a response by Sara Harder regarding the facility fee. She states that there is confusion on the part of the IHC between calculating facility (ambulatory surgery) and physician charges and notes that the sources used, CPT Book, CPT Assistant, and the CPT Changes: An Insider's View, are sources to be used for the physician billing and not applicable to facility billing. Therefore, the guidelines applied are incorrect. Ms. Harder states that in contrast to the IHC's analysis, for ambulatory surgery facility billing if modifier 59 is not applied, in most instances no payment will be allowed whether the code is identified as an add on coder according to the CPT book or not. As clarification she notes the procedures were all performed at the same levels C4-C5 and C5-C6. The Coder states that CPT 63075 was allowed and should have been allowed and CPT code 63076 for procedures performed at the second level should be allowed. However, since 22526 and 22527 were performed at these **same levels**, the modifier was improperly applied, and no payment was allowed. By allowing CPT 63075 and 63076 the two treated spinal levels are accounted for. Since CPT 22526 and 22527 were also performed in these same two spinal levels, the modifier is not appropriate and the allowable fee for these codes would consolidate. Therefore, she reiterates the reimbursement due and owed is \$2605.78.

Applicant's counsel has submitted a letter in response to the IHC noting:

"The IHC report confirms applicant's position on the Fee Schedule. We ask that an award be issued for \$7817.34 for codes 63076, 22526 and 22527 as found by Applicant's coder as well as the IHC. We submit this response because there is a minor discrepancy in the IHC report regarding code 63076. Code 63076 has not been paid, although the IHC report mistakenly lists that Respondent paid \$9007.81 for 63075 and 63076. At the hearing, Respondent agreed that 63076 is owed to Applicant, but that payment has not been issued."

What I find to be the issue in this case is that the Respondent's coder does note NCCI has established "edits" to determine whether certain codes may be billed together and notes there is no NCCI (Coding) edit between the codes billed. Ms. Vinogradov, Applicant's coder also agrees there is no NCCI edit. As noted by Respondent's coder, this does not mean however the application of modifier -59 is automatically applied and the criteria based on the guidelines outlined (separate session/different anatomic site) still need to be met and if not the modifier is improper for FACILITY billing. Upon my review I note the operative report indicates all procedures were performed at the C4-C5 and C5-C6 and which are the same levels. The IHC disagrees with the Respondent's Coder regarding modifier -59 being appended to CPT 22526 since she opines the annuloplasty a *different procedure* was performed during the same date of service as the discectomy.

I am more persuaded by the argument and analysis set forth by the Respondent. I find the modifier should not have been appended as the Codes billed were for the same session, performed at the same level of the cervical spine as clearly discussed above. Modifier 59 is used to override a payment restriction, meaning, by default, the service or procedure is not eligible for reimbursement. By appending -59 to the CPT code, the provider (or facility) is conveying a message in shorthand: the service that stands to get denied is not inclusive to other services reported on the bill, and therefore, it should be paid. To be certain, appending a modifier to a code does not, in and of itself, render the service payable. Its use must be justified with supporting documents. In this case, considering the operative report and the code descriptors and analysis set forth, I find Applicant's use of modifier 59 to be improper.

The Applicant is therefore awarded an additional \$2605.79, plus interest, an attorney's fee and the arbitration filing fee, as outlined below in Sections A through D below. The remainder of the claim is hereby 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 applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Amount Amended	Status
	Rockaways ASC Developme nt LLC d/b/a ASC of Rockaway Beach	09/19/21 - 09/19/21	\$9,629.95	\$7,817.34	Awarded: \$2,605.78
Total			\$9,629.95		Awarded: \$2,605.78

B. The insurer shall also compute and pay the applicant interest set forth below. 07/12/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest on the above-awarded amount shall be computed and paid at a rate of 2% per month, simple, commencing on the date the claim was filed in arbitration and ending with the date of payment of the award.

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 total of the awarded claim plus interest, subject to a maximum of \$1,360.

- 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 NY

SS :

County of Nassau

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

06/08/2023

(Dated)

Maryann Mirabelli

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:
586ef54be9df8948548525ed94a230e8

Electronically Signed

Your name: Maryann Mirabelli
Signed on: 06/08/2023