American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Triborough ASC (Applicant)	AAA Case No.	17-22-1276-1224
	Applicant's File No.	00106579
- and -	Insurer's Claim File No.	20-1067211
	NAIC No.	24279
Progressive Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Kent Benziger, 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: A.A.

1. Hearing(s) held on 07/05/2023
   Declared closed by the arbitrator on 07/05/2023

   Justin Rosenbaum, Esq. from Drachman Katz, LLP participated virtually for the Applicant

   Ashley Sforza, Esq. from Progressive Casualty Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$4,027.18**, 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

   On October 21, 2020, the Assignor/Eligible Injured party, a 24-year-old male, was, by history, involved in a motor vehicle accident. In dispute is the proper ambulatory surgical fee for cervical epidural steroid injections, trigger point injections and epidurogram performed at Triborough ASC on January 29, 2021.

   The Respondent has withdrawn its medical necessity defense based on an independent medical examination. The sole issue is fee schedule. The Respondent has submitted an

affidavit from Sarah Harder, a certified medical coder while Applicant has submitted an affidavit from Ester Tetro, also a certified coder. The primary issue is whether CPT C ode 72275 is separately reimbursable.

This hearing was conducted using the electronic case folder maintained by the American Arbitration Association. All documents contained in that folder are made part of the records of this hearing. I have reviewed the documents contained in the electronic case folder as of the date of this award as well as any documents submitted upon continuance of the case. Any documents submitted after the hearing that have not been entered in the electronic case folder as of the date of this award will be listed immediately below and forwarded to the American Arbitration Association at the time this award is issued for inclusion in said case folder.

4. Findings, Conclusions, and Basis Therefor

On October 21, 2020, the Assignor/Eligible Injured party, a 24-year-old male, was, by history, involved in a motor vehicle accident. Following the accident, the Assignor was evaluated at Lincoln emergency room where a CT scan was performed.

On October 26, 2020, an evaluation was performed at Gurvansh Anand Chiropractic for complaints of headaches, cervical and lumbar pain. Decreased range of motion and positive orthopedic tests were noted. The assessment included cervical and lumbar sprains/strains, subluxations and segmental and somatic dysfunction. The Assignor commenced chiropractic treatment.

On October 27, 2020, the Assignor was evaluated by Dr. Jordan Fersel for complaints of headaches, cervical, thoracic and lumbar pain. The levels of pain were reported as 8-10/10. On examination, cervical and lumbar range of motion were decreased. The assessment included headaches, cervical, thoracic and lumbar spine pain. An occipital nerve block was performed and a physical therapy were prescribed . Tizanidine and lidocaine were prescribed.

On November 12, 2020, a cervical MRI study was performed which revealed posterior bulges at C2-3 and C3-4 both impinging on the thecal sac with a right foraminal disc herniation impinging on the right C4 nerve root and left existing nerve rot as well as foraminal stenosis.

On November 13, 2020, a lumbar MRI study was performed with a posterior bulging disc at L3-4 and a broad-based posterior bulge at L4-5 disc level impinging upon the

anterior thecal sac with encroachment into the foramina bilaterally resulting in mild to moderate central canal and bilateral foraminal stenosis and encroachment on the exiting L4 nerve roots and a posterior bulge at the L5-S1 disc level.

On January 21, 2021, the Assignor had an initial consultation from August Igbokwe, P.A. The Assignor's complaints included neck and low back - both 10/10 and right shoulder pain 9/10. On examination, the Assignor had moderate tenderness, positive straight leg raising, positive Facet loading. The clinical assessments was of cervical and lumbar radiculopathy, myalgia, fibro myositis facet syndrome and right shoulder pain. The case was listed as discussed with Mark Gladstein. A continuation of physical therapy was recommended as was Diclofenac

On January 29, 2021, Dr. Cristy Perdue performed cervical epidural steroid injections, trigger point injection and epidurogram at Triborough ASC. The pre and post-operative diagnosis was of cervical radiculopathy, myofascial pain with trigger points. the Assignor was evaluated at Triborough ASC. The Applicant Triborough ASC submitted a UB-04 claim form for the service totaling $4,027.18.

Denial/IME. The Respondent issued a denial based on an independent medical examination (hereinafter referred to as an IME). However, the Respondent has now stipulated to withdraw this defense. The sole issue is fee Schedule.

Respondent's Coder. The Respondent has submitted an affidavit from Sarah Harder, a certified medical coder. Ms. Harder calculated the new Enhanced Ambulatory Payment Groups (EAPG) Fee Schedule applicable to Ambulatory Surgical Centers. She stated that Progressive elected to manually calculate the EAPG adjustments as opposed to solely using 3M software. Ms. Harder discussed the use of "NCCI edits":

> According to the NYS DOH website the Ambulatory Patient Groups (APGs) Medicaid Fee-For-Service Provider Manual Policy and Billing Guidelines revised 12/29/21, page 18, 3.8 National Correct Coding Initiative (NCCI) Edits, "NCCI edits were developed by CMS to support national practice, coding and billing standards. NCCI edits are utilized by Medicare and most private insurers and reflect nationally accepted correct coding standards. NCCI edits are used to prevent inappropriate reimbursement of services that should not be reported together for the same date of service by the same provider; services that are integral to another comprehensive service separately coded; and services
> that should never be performed with another service or procedure. The. provider may need to append an applicable modifier on a claim line to indicate multiple, distinct patient encounters, provider by the same provider, on the same date of

service to reflect the nature of service provided". Additional information regarding NCCI edits, and the use of modifiers, is available on the DOH website at: https://www.health.ny.gov/health care/medicaid/rates/apg/docs/ncci edits applied apgcl aims.pdf. Attached at **Exhibits "5".**

Ms. Harder then discussed that the calculation for the maximum amount permitted under EAPG is the "APG Code Weight" multiplied by the "New York Workers Compensation Base Rate" which equals the subtotal. She state the Capital Add-On then gets added where appropriate in order to arrive at the total payment for the primary APG group. For the downstate region, the NY WCB rate is $295.94 with Capital Add-On is $81.37 for Ambulatory Surgery Centers. She then noted that the provider did not bill modifier 59 for any of the procedures billed and as the procedures were performed at the same Anatoic site, no additional payment can be permitted. Her calculations include the following:

As set forth in the implementation guide " .. .Significant procedure consolidation refers to the collapsing of multiple related significant procedure APGs into a single APG for the purpose of determining payment. ..." Discounting refers to a reduction in the standard payment rate for an APG. The APG payment system applies discounting when multiple *unrelated/bilateral* significant procedures are performed, or the same ancillary service is performed multiple times during a visit. Review of the EAPG Schedules in the 3M APG Crosswalk database assigns CPT Code 62321 to APG Group 53, CPT Codes 20553 to APG Group 49. These services are um elated / bilateral. The application of the predetermined weight, discounts , rate, capital add on result in CPT Code 62321 being compensated at 100% of the EAPG amount of $976.38. The application of the predetermined weight, discounts, rate, result in CPT Code 20553 being compensated at 50% of the EAPG amount of $473.38 at 50% payable amount is $236.69. Attached at **Exhibits "6"** and "7" are copies of the relevant APG Groups from the 3M APG Crosswalk database, APG Weight Listing and Manual Calculation Sheet.

Codes 72275 and 77003: 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.

Code Q9965 is assigned to APG Group 2001, **Code JllOO** is assigned to APG Group 496, and **Code 99072** is assigned to APG Group 1001: these APGs have a pre- determined weight of 'O' .

Code 82948- This service is packaged and does not warrant a separate payment according to the New York Enhanced Ambulatory Patient Grouping (EAPG) methodology.

Code J3490- This charge has been evaluated as a Carve-out service using the procedure guidelines from the New York Enhanced Ambulatory Patient Grouping (EAPG) methodology. This edit can be reviewed at http://www.health.ny.gov/health care/medicaid/rates/methodology/.

> Attached at **Exhibit "8"** is the "Policy and Billing Guidance Ambulatory Patient Groups (APGs) Provider Manual," which addresses billing and discounting procedures.
>
> Based on my review of the claim and the claim handling for the bills in dispute, the applicant is only entitled to $1,213.07, 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.

Applicant's Coder. The Applicant has submitted a fee affidavit from Ester Tetro, also a certified fee coder. Ms. Tetro states the following formula for the calculation of each performed procedure is as follows:

> *(NYS WCB EAPG Base Rate) x (Weight Multiplier) x (APG Base-Rate) + (Capital Add-On Payment)*

Ms. Tetro agrees that with Ms. Harder with the proper reimbursement of CPT 62321 and 20553 and that CPT Q9965, 11100, 13490, 77003 and 82948 are not reimbursable. However, Ms. Tetro disagrees with Ms. Harden as to CPT 72275 which Ms. Tetro finds is separately reimbursable at $572.52. Ms. Tetro states the following:

> Code 72275 is a column 2 code, which means that it is bundled into Code 62321 **unless** it's proven that both services are distinct and separately identifiable from one another.
> With that being said, CPT" further elaborates on 72275 use in the parenthetical notes beneath the code.
>
> Specifically, CPT® states the following:
> "(For injection procedure, see 62280, 62281, 62282, 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327,
> 64479, 64480, 64483, 64484).
> "(Use 72275 only when an epidurogram is performed, images documented, and a formal radiologic report is issued)."

Ms. Tetro found that to permit billing for CPT 72275, a separate epidurogram consisting of a diagnostic study must be performed. .From her review of the operative report, Ms. Tetro found the standard was met. Her final calculations were as follows:

> 62321 APG Group -53 APG Wt -3.0243 Mult. -100% Total $895.01
>
> 20553 APG Group -49 APG Wt -1.5996 Mult. - 50% Total $236.69

72275 APG Group -474 APG Wt -1.9346 Mult. -100% Total $572.52

Total - $1,704.22 Capital Add On: $81.37 Final APG Payment $1,785.59

Analysis. Pursuant to the Fourth Amendment effective April 1, 2013 to 11 NYCRR 65-3.8(g)(1), the Applicant's fees cannot exceed the charges permitted pursuant to the Insurance Law 5108 which would incorporate the Workers Compensation Fee Schedule. If there is a dispute that requires an application or interpretation of the fee schedule, the Respondent has the burden to come forward with competent evidentiary proof to support its defenses. Robert Physical Therapy. Once a Carrier has established that the amounts billed were in excess of the fee schedule, the burden shifts to the provider to show that establish a different interpretation, miscalculation or error. Cornell Medical P.C. v. Mercury Casualty Co., 24 Misc. 3d 58, (App Term 2d, 11th & 13 Dist. 2009

In this instance, Ms. Harden's affidavit is persuasive as to all issues except CPT 72275. Except for the billing for CPT 72275, the Applicant's Coder agrees with Ms. Harden's rationale. However, Ms. Tetro states that CPT code 72275 is separately reimbursable when a separate epidurogram is performed for diagnostic purposes. She found this occurred and cited the Code's description to support this contention. As to this Code, the Applicant's Coder is more persuasive. Ms. Tetro's EAPG calculations - which are substantially reduced from the original amount billed - are persuasive.

Pursuant to 11 NYCRR 65-4.5 (o)(1)(i)(ii), an arbitrator is the judge of the relevance and materiality of the evidence offered.

Interest. The insurer shall compute and pay to the Applicant the amount of interest from the filing date of the Request for Arbitration, at a rate of 2% per month, simple interest (i.e. not compounded) using a 30-day month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

Attorney's Fees. As said case was filed on or after February 4, 2015, Applicant is awarded attorney's fees for the total amount of first party benefits awarded. Pursuant to 11 NYCRR 65-4.6(d)(e), the Applicant is awarded 20 percent of the amount of the first party-benefits, with no minimum fee and a maximum $1,360.00 which is the total amount awarded one Applicant in one action from one provider. See: LMK Psychological Services, P.C. v. State Farm Mut. Auto Ins. Co., 46 A.D.3d 1290; 849 N.Y.S.2d 310 (3 Dept. 2007).

APPLICANT IS AWARDED REIMBURSEMENT OF $1,785.59, TOGETHER WITH INTEREST AND ATTORNEYS' FEES.

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**
	Triborough ASC	**01/29/21 - 01/29/21**	**$4,027.18**	**Awarded: $1,785.59**
Total			**$4,027.18**	**Awarded: $1,785.59**

B. The insurer shall also compute and pay the applicant interest set forth below. 11/23/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   Interest. The insurer shall compute and pay to the Applicant the amount of interest from the filing date of the Request for Arbitration, at a rate of 2% per month, simple interest (i.e. not compounded) using a 30-day month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

C. Attorney's Fees

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

Attorney's Fees. As said case was filed on or after February 4, 2015, Applicant is awarded attorney's fees for the total amount of first party benefits awarded. Pursuant to 11 NYCRR 65-4.6(d)(e), the Applicant is awarded 20 percent of the amount of the first party-benefits, with no minimum fee and a maximum $1,360.00 which is the total amount awarded one Applicant in one action from one provider. See: LMK Psychological Services, P.C. v. State Farm Mut. Auto Ins. Co., 46 A.D.3d 1290; 849 N.Y.S.2d 310 (3 Dept. 2007).

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 Orange

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

08/02/2023
(Dated)

Kent Benziger

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:
b0650c47ab3765382b96761070139bf1

Electronically Signed

Your name: Kent Benziger
Signed on: 08/02/2023