American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

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| Pain Medicine Treatment PLLC (Applicant) | AAA Case No. | 17-22-1266-8870 |
| | Applicant's File No. | BT22-181247 |
| - and - | Insurer's Claim File No. | 32-29S2-92B |
| | NAIC No. | 25178 |
| State Farm Mutual Automobile Insurance Company (Respondent) | | |

**ARBITRATION AWARD**

I, Pamela Hirschhorn, 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: Injured Person

1. Hearing(s) held on 08/25/2023
   Declared closed by the arbitrator on 08/25/2023

   Erica Avella, Esq. from The Tadchiev Law Firm, P.C. participated virtually for the Applicant

   Joseph Licata, Esq. from Rossillo & Licata LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$3,725.47**, was AMENDED and permitted by the arbitrator at the oral hearing.

   $1,460.25.

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

3. Summary of Issues in Dispute

   The injured person was a 42-year-old female who was involved in the subject motor vehicle accident of January 22, 2022. The claim is for a lumbar discectomy performed on May 15, 2022. The claim was partially reimbursed and the balance was denied based

upon a fee schedule defense. The issue is whether the respondent established prima facie that the services were billed in excess of the fee schedule.

4. Findings, Conclusions, and Basis Therefor

The injured person was a 42-year-old female who was involved in the subject motor vehicle accident of January 22, 2022. The claim is for the surgeon's services and physician assistant's services in connection with a lumbar discectomy performed on May 15, 2022.

The surgery was billed in the amount of $9,403.60. Respondent issued reimbursement in the amount of $5,678.13, leaving a disputed balance of $3,725.47. At the time of hearing, the applicant's counsel amended the amount in dispute to $1,460.25, pursuant to applicant's fee coder's fee audit.

The respondent submitted a fee audit by Stephanie A. Brown, CPC, CPMA. Ms. Brown provided the following breakdown of the claim:

| LINE | DOS | BILLED CPT CODE | AMOUNT BILLED | CPT CODE DEFINITION | CORRECT CPTCODE | CORRECT REIMBURSEMENT |
|---|---|---|---|---|---|---|
| I | 05/15/22 | 62287 | $2,862.04 | Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle-based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, | NA | $0.00 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | with the use of an endoscope, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar | | |
| 2 | 05/15/22 | 22526 59 | $2,738.59 | Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level | 22526 | $2,738.59 |
| 3 | 05/15/22 | 22527 59 | $2,217.07 | Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; l or more additional levels (List separately in addition to code for primary procedure) | 22527 | $2,217.07 |
| 4 | 05/15/22 | 62290 59 | $390.51 | Injection procedure for discography, | NA | $0.00 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | each level; lumbar | | |
| 5 | 05/15/22 | 72295<br><br>59 | $317.11 | Discography, lumbar, radiological supervision and interpretation | NA | $0.00 |

| LINE | DOS | BILLED CPT CODE | AMOUNT BILLED | CPT CODE DEFINITION | CORRECT CPTCODE | CORRECT REIMBURSEMENT | RAT |
|---|---|---|---|---|---|---|---|
| | | Total | $8:525.32 | | Total | $42955.66 | |

Ms. Brown found that the total Amount Billed $8,525.32, and the total amount allowed for the surgeon's services is $4,955.66

| LINE | DOS | BILLED CPT CODE | AMOUNT BILLED | CPT CODE DEFINITION | CORRECT CPTCODE | CORRECT REIMBURSEMENT |
|---|---|---|---|---|---|---|
| 1 | 05/15/22 | 62287<br><br>83 | $306.24 | Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle-based technique to remove disc material under fluoroscopic | NA | $0.00 |

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|---|---|---|---|---|---|---|
| | | | | imaging or other form of indirect visualization, with the use of an endoscope, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar | | |
| 2 | 05/15/22 | 22526<br><br>59 83 | $293.03 | Percutaneous intradiscal electrothe1mal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level | 22526 | $293.03 |
| 3 | 05/15/22 | 22527<br><br>59 83 | $237.23 | Percutaneous intradiscal electrothennal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure) | 22527 | $237.23 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 4 | 05/15/22 | 62290<br><br>59 83 | $41.78 | Injection procedure for discography, each level; lumbar | NA | $0.00 |
| | | Total | $878.28 | | Total | $530.26 |

Ms. Brown found that the total amount billed was $878.28, and the total amount allowed for the physician assistant's services is $530.26.

Ms. Brown noted that CPT code 22527 according to the Official New York Workers' Compensation Medical Fee Schedule, Surgical Fee Schedule has a total allowable of $2,217.07 based on the geographic location of the services rendered. Reimbursement was calculated by the following formula: surgical conversion factor 251.94 X relative value unit 8.80 = 2,217.07.

Ms. Brown stated that as per the Official New York Workers' Compensation Medical Fee Schedule, Intro and General Guidelines Ground Rule 13, (Add-on procedures are not subject to the multiple procedure rule and, as such, modifier 51, does not apply. Fee schedule amounts for add-on codes are not subject to reduction and should be reimbursed at the lesser of 100 percent of the listed value or the billed amount.)

Ms. Brown noted that CPT code 22527 83 according to the Official New York Workers' Compensation Medical Fee Schedule, Surgical Fee Schedule has a total allowable of$237.23 based on the geographic location of the services rendered. Reimbursement was calculated by the following formula: surgical conversion factor 251.94 X relative value unit 8.80 = 2,217.07 @10.7% = 237.23.

Ms. Brown noted that as per the Official New York Workers' Compensation Medical Fee Schedule, Surgical Fee Schedule Ground Rule 5 (When multiple procedures, unrelated to the major procedure and adding significant time or complexity, are provided at the same operative session, payment is for the procedure with the highest allowance plus half of the lesser procedure.)

Ms. Brown noted that as per the Official New York Workers' Compensation Medical Fee Schedule, Surgical Fee Schedule Modifier 83 (When a physician assistant or nurse practitioner performs services for assistants at surgery, identify the service by adding modifier 83 to the usual procedure code.)

Ms. Brown noted that as per the Official New York Workers' Compensation Medical Fee Schedule, Surgical Fee Schedule Guidelines Ground Rule #12.F (Services of physician assistants and nurse practitioners assisting during surgical procedures will be paid at two-thirds of the surgical assistant percentage 16 percent. Physician assistants will receive I 0.7 percent of the total allowance for the surgical procedures.)

Ms. Brown noted that CPT code 22526 according to the Official New York Workers' Compensation Medical Fee Schedule, Surgical Fee Schedule has a total allowable of$2,738.59 based on the geographic location of the services rendered. Reimbursement was calculated by the following formula: surgical conversion factor 251.94 X relative value unit I 0.87 = 2,738.59.

Ms. Brown noted that as per the Official New York Workers' Compensation Medical Fee Schedule, Surgical Fee Schedule Ground Rule 5 (When multiple procedures, unrelated to the major procedure and adding significant time or complexity, are provided at the same operative session, payment is for the procedure with the highest allowance plus half of the lesser procedure.)

Ms. Brown noted that CPT code 22526 83 according to the Official New York Workers' Compensation Medical Fee Schedule, Surgical Fee Schedule has a total allowable of$293.03 based on the geographic location of the services rendered. Reimbursement was calculated by the following formula: surgical conversion factor 251.94 X relative value unit 10.87 = 2,738.59@ 10.7% = 293.03.

Ms. Brown noted that as per the Official New York Workers' Compensation Medical Fee Schedule, Surgical Fee Schedule Ground Rule 5 (When multiple procedures, unrelated to the major procedure and adding significant time or complexity, are provided at the same operative session, payment is for the procedure with the highest allowance plus half of the lesser procedure.)

Ms. Brown noted that as per the Official New York Workers' Compensation Medical Fee Schedule, Surgical Fee Schedule Modifier 83 (When a physician assistant or nurse practitioner performs services for assistants at surgery, identify the service by adding modifier 83 to the usual procedure code.)

Ms. Brown noted that as per the Official New York Workers' Compensation Medical Fee Schedule, Surgical Fee Schedule Guidelines Ground Rule #12.F. (Services of physician assistants and nurse practitioners assisting during surgical procedures will be paid at two-thirds of the surgical assistant percentage 16 percent. Physician assistants will receive 10.7 percent of the total allowance for the surgical procedures.) Ms. Brown stated that as per the Complete Global Service Data for Orthopaedic Surgery 2018, CPT codes 62287 and 62290 are not to be reported when billed along with CPT code 22526 (Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level) as they are considered to be inclusive to CPT code 22526.

Therefore, Ms. Brown found that reimbursement is $0.00.

Ms. Brown found that CPT code 72295 has been reported by the provider in error.

Ms. Brown stated that as per CPT Guidelines, CPT code 72295 should not be reported in conjunction with CPT code 62287.

Ms. Brown stated that as per CPT Guidelines: (Do not report CPT code 62287 in conjunction with 62267, 62290, 62311, 77003, 77012, 72295 when performed at the same level) Therefore, Ms. Brown stated that reimbursement is $0.00.

Ms. Brown found that modifier 59 was appended incorrectly to the CPT codes.

Ms. Brown stated that as per CPT Guidelines, modifier 59 is to be appended to a CPT code when a distinct procedural service is performed. CPT Guidelines on the use of modifier 59 say, 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.

Ms. Brown stated that all services were performed on the lumbar area.

Thus, the total amount billed was $9,403.60. State Farm paid $5,678.13, overpaying the provider $192.21.

This arbitrator finds that the respondent's fee coder provided a thorough review of the fee schedule and thus respondent's fee coder's fee audit constituted prima facie proof that the services were billed in excess of the fee schedule.

Applicant submitted a fee audit by Naira Margaryan, CPC, CPMA, CPCO, CRC, CPCI, CPPM. Applicant's fee coder stated that the formula for calculation of payment for each performed procedure/CPT in New York State for physician and physician's assistants is as follows:

***(NYS WCB RVU) x (Conversion Factor) x (Multiple Procedure Reduction, if applicable) x (Ground Rule 12(f), if applicable)***

The applicant's fee coder stated that the points of contention are regarding codes 62287 and 62287-83. It was noted that Ms. Brown denied reimbursement for code 62287 (and 62287-83) by citing to an AAOS article, which is published by the Complete Global Service Data for Orthopaedic Surgery, but applicant's fee coder stated that AAOS is not a proper authoritative source,

Applicant's fee coder found that code 62287 was properly reported and billed based on the Operative Report, and there is no basis to consolidate code 62287 into code 22526 based on any CPT Assistant article, the Workers' Compensation Medical Fee Schedule Ground Rules, or any other authoritative source. Accordingly, the applicant's coder found that code 62287 is reimbursable in the amount of $2,862.04.

The applicant's coder stated that since code 62287 is the main code on the bill rather than code 22526, the multiple procedure reduction rules apply to code 22526. The applicant's coder concluded that code 22526 is reimbursable for $1,369.29.

The applicant's coder agreed that physician's assistants are reimbursed according to General Ground Rule 15. Modifier 83 is appended to indicate that the billed code was performed by a physician's assistant. General Ground Rule 15 states that when Modifier 83 is appended, the fee is 10.7% of the surgeon's fee.

The applicant's coder stated that code 62287-83 should be reimbursed according to General Ground Rule 15. Applying the 10.7% reduction results in a fee amount of $306.24 for code 62287-83. Since code 62287-83 is the main code on the physician assistant's bill, the applicant's coder stated that the multiple procedure reduction rules apply to the remaining codes. Thus, code 22526-83 is reimbursable for $146.51.

The applicant's coder found that the total fee schedule amount for the surgery services is $7,138.38. Since the carrier paid the applicant the sum of $5,678.13, The applicant's fee coder found that $1,460.25, is owed.

This arbitrator has considered the evidence and finds respondent's fee coder's fee analysis to be more persuasive. The respondent's fee coder set forth with specificity the basis for the fee reduction in this case. This arbitrator is persuaded that the reduction is in accordance with the fee schedule.

Accordingly, the claim for further reimbursement 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 NY
SS :
County of Nassau

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

08/28/2023
(Dated)

Pamela Hirschhorn

**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:**
c74acf4689ca9ccac57f4361a864f8e3

**Electronically Signed**

Your name: Pamela Hirschhorn
Signed on: 08/28/2023