American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Uptown Healthcare Management Inc d/b/a ETM- ASC Ambulatory Surgery Center of East Tremont (Applicant)	AAA Case No.	17-22-1278-7261
	Applicant's File No.	TLD22-1013729
	Insurer's Claim File No.	32-30R8-35K
- and -	NAIC No.	26816
State Farm Mutual Automobile Insurance Company (Respondent)		

ARBITRATION AWARD

I, Stacey Erdheim, 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: Claimant

1. Hearing(s) held on 09/27/2023
   Declared closed by the arbitrator on 09/27/2023

   Jodi-Ann Chambers from Thwaites, Lundgren & D'Arcy Esqs participated virtually for the Applicant

   John Rosillo from Rossillo & Licata LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$13,019.43**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The record reveals that Claimant (WW) was involved in a motor vehicle accident on 2/18/22. Applicant seeks the balance of the services rendered on 7/30/22 in the amended amount of $5596.43. Respondent's defense is based on a fee schedule defense.

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

3. Summary of Issues in Dispute

The record reveals that Claimant (WW) was involved in a motor vehicle accident on 2/18/22. Applicant seeks the balance of the services rendered on 7/30/22 in the amended amount of $5596.43. Respondent's defense is based on a fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the ADR Case Folder as of the date of the hearing in this matter and have considered all documents contained therein for the purpose of rendering this award. No additional documentation was submitted by either party at the time of the hearing.

The Arbitrator shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to legal rules of evidence shall not be necessary. 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. 11 NYCRR 65-4.5(o)(1). (Regulation 68-D.)

The record reveals that Claimant (WW) was involved in a motor vehicle accident on 2/18/22. Applicant seeks the balance of the services rendered on 7/30/22 in the amended amount of $5596.43. Respondent's defense is based on a fee schedule defense.

It is settled Law that to recover assigned first party No-Fault benefits, a provider establishes a prima facie entitlement to an award by proof of submission of statutory claim forms setting forth the fact and amounts of the losses sustained, and a payment of No-Fault benefits was overdue. (*See Insurance Law 5106 (a); Mary Immaculate Hospital v. Allstate Ins. Co., 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]; Amaze Medical Supply, Inc. v. Eagle Ins Co., 2 Misc. 3d 128A, 784 N.Y.S. 2d 918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists*]). Additionally, acknowledgment of receipt of the bill in its denial is proof of submission of the claim. (*See Careplus Med. Supply Inc. v. State-wide Ins. Co., 11 Misc 3d 29, 812 NYS2d 736 [App Term, 2nd & 11 Jud Dists 2005*]). Applicant has met its burden in the case at hand.

Applicant argues that Respondent has not met its burden with regard to the defense that these charges are not in accordance with the fee schedule. The burden is on the insurer with respect to a defense that the fees charged were in excess of the Workers' Compensation Fee Schedule. (*St. Vincent Medical Services, P.C. v. Geico Ins. Co., 29 Misc. 3d 141(A), 2010 NY Slip Op 52153(U) (Sup Ct. App. T. 2d Dep't 2010);* also see *Rogy Med. P.C. v. Mercury Cas. Co., 23 Misc. 3d 132 (A), 2009 NY Slip Op 50732 (U) (Sup. Ct. App. T. 2d Dep't 2009*).

Respondent's counsel contends that Applicant over billed for ambulatory surgical facility fees. In support of its position, the Respondent submits an affidavit from Becky Neve, CPC., who contends that Respondent paid the proper amount of $3026.24.

CPT code 29881 was reported for "Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed". The documentation supports this code as billed. CPT code 29884, has the AMA CPT distinction of being a "separate procedure". A "separate procedure" by definition, is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services it may be reported. The operative report shows that the lysis of adhesions was performed, however, it was performed with a more complex service, therefore, 29884 should not be reported. The NCCI Procedure-to-Procedure Edits also include 29884 in 29881. (see the table for this code in the following section "EAPG Calculations", being included for demonstrative purposes.) CPT code 29874 was reported for "Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)." The NCCI Procedure-to [1]Procedure Edits include 29874 in 29881. The use of modifier 59 is not relevant as the modifier is never allowed with this code combination. (see the table for this code in the following section "EAPG Calculations", being included for demonstrative purposes.) CPT code 29876 was reported for "Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (eg, medial or lateral)". The documentation supports this code but does not support modifier 59. CPT code 29875 was reported for "Arthroscopy, knee, surgical; synovectomy, limited." This code has the AMA CPT distinction of being a "separate procedure". A "separate procedure" by definition, is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services it may be reported. The operative report shows a synovectomy was performed, however, it was performed in all three compartments. The correct code for the service performed is 29876, which the facility has also reported. It would never be appropriate to report 29875 in addition to 29876. Only one or the other would be reported, depending on the number of compartments. CPT code 29999 is used to report "Unlisted procedure, arthroscopy", and was reported in this case for coblation arthroplasty. The documentation supports this code but does not support modifier 59. CPT code 20610 was reported for an injection of Marcaine/lidocaine into the knee at the conclusion of the procedure for "post-operative anesthesia". This is considered to be an inclusive component of the surgery and should not be reported as a separate service. The NCCI Procedure-to-Procedure edits, also include 20610 in 29881. (see the table for this code in the following section "EAPG Calculations", being included for demonstrative purposes.) This injection would have to be performed to the other knee or a different joint to support the use of modifier 59. When a surgeon performs multiple procedures, it may be appropriate for him/her to report modifier 59 because of the work they are doing. The facility has not performed any additional services beyond the use of the operating room, staff and what is normally used and carried out during the procedure. Nothing changed for the facility because the surgeon performed multiple procedures to the same knee through the same portals at the same encounter. If the surgeon were to perform a service on a separate body area during the same session, then Modifier 59 would be supported.

For example, if an ankle arthroscopy were also performed at the same operative session, this would require additional operating room time and staff time, and it would be appropriate to append Modifier 59 to the second anatomic site. When performing a surgery on a knee, it is standard practice to address all abnormalities found within the same surgical session. A surgeon would not perform a surgery one day to address the torn meniscus and then perform a second surgery on a different day to address the synovitis. This is what is meant by ordinarily performed and encountered on the same day. Standard arthroscopic surgery utilizes multiple portals, which does mean multiple small incisions. That is the benefit of arthroscopic surgery vs a standard open procedure which would involve one large incision. Even if the surgeon were doing only one procedure (ie 29881), multiple portals would be created. The fact that the provider is doing multiple procedures through the same portals does not mean that Modifier 59 should be automatically applied, because the surgery cannot be performed without them. In this case 3 portals were established before any procedure was carried out. Summary: It is important to note that coding for physician services is different from coding for facility services. While a physician may be reimbursed separately for each procedure performed, the facility is reimbursed for the operative session. This is supported by the information contained in the APG Provider Manual - 1.2 Overview of APG Reimbursement Methodology (see Exhibit E) "APGs are designed to include all types of resources used during an ambulatory or clinic visit, including but not limited to, professional services, pharmaceuticals, supplies, ancillary tests, equipment utilization, types of rooms, and treatment time. APG's are designed to group procedures and medical visits that share similar resource utilization and costs. Similar resource utilization means that the resources used for a procedure or medical visit are relatively consistent across all patients assigned to an APG. The level of resource utilization is taken into consideration in the calculation of the APG reimbursement made to the provider." (emphasis added). When a facility reports more than one CPT code and appends modifier 59, the resulting reimbursement could be in a range of approximately $3,000.00 to $17,000.00, or more. In this case the facility is seeking over $16,045.67. This large variation in facility payment for the same arthroscopic shoulder surgery would be in conflict with the overview statement that the resources used are relatively consistent across all patients. All of the CPT codes reported are assigned to the APG category of 37. APG 37 is classified as a Significant Procedure - Level 1 Arthroscopy. All CPT codes assigned to this APG share similar characteristics and utilize the same amount of resources. APG Category of 37 is also assigned a Final EAPG Type of 2 - Significant Procedure. (This information is derived from the 3M output report) The 3M grouper software that is utilized in the EAPG payment methodology is designed to consolidate multiple related significant procedures into a single APG for determining reimbursement. The consolidation applicable on this bill is considered to be "same EAPG consolidation". The 3M document "Frequently Asked Questions: Implementing the 3M Enhanced Ambulatory Patient Grouping System provides the following explanation:

Applicant relied upon a fee coder analysis by Priti Kumar who acknowledges that Applicant did in fact bill in excess of the fee schedule. Ms. Kumar agrees with Respondent with respect to codes 29884, 29876, 29875 and 20610. Her analysis is

limited to codes 29874 and 29999. It is also important to note that Applicant's own audit states that Applicant billed the improper code and seeks to now change the code to get reimbursed.

Regarding CPT Code 29874: Operative report indicated Applicant has billed significant procedures of "Removal of loose bodies" under Code 29874. Respondent's coder has denied reimbursement for code 29874 stating "The NCCI Procedure-to-Procedure Edits include 29874 in 29881. The use of modifier 59 is not relevant as the modifier is never allowed with this code combination." While, I do not disputes that NC CI Edits do not allowing billing of Code 29874 and 29881 together. However, Respondent's coder has overlooked the fact that NCCI Edit Policy Manual has provided the exception for billing of significant procedures of ""Removal of loose bodies" performed in separate compartment ofthe knee joint separately under CPT Code G0289 along with the procedures of "meniscectomy" reportable under Code 29881. AMA Define CPT Code G0289: Surgical knee arthroscopy for removal of loose body, foreign body, debridement/shaving of articular cartilage at the time of other surgical knees that arthroscopy in a different compartment of the same knee; NCCI Edits which are also the relevant part of the EAPG Methodology has provided exception for Billing of Code G0289 separately along with other arthroscopic procedures. Chapter IV of NCCI Edit Policy Manaul Section E Arthroscopy Subsection (6) …With two exceptions HCPCS code G0289 (Surgical knee arthroscopy for removal of loose body, foreign body, debridement/shaving of articular cartilage at the time of other surgical knee that arthroscopy in a different compartment of the same knee) may be reported with other knee arthroscopy codes. …HCPCS code G0289 may be reported with CPT codes 29880 or 29881 for removal of a loose body or foreign body from a different compartment of the same knee." (Emphasis added) 9. Here, Operative report clearly indicated that while the procedures of "menicectomy" reported under Code 29881 was performed only in the "medial compartment". Whereas, the Significant Procedures of "removal of loose bodies" was performed in the medial as well as lateral compartment thus the procedures performed in lateral compartment, that is, separate compartments of the knee joint is separately reportable under Code G0289. The Operative report at its relevant part clearly described the procedures performed "…At this point, multiple small soft tissue and chondral loose bodies were noted in the medial and lateral gutters, some of which were measured to be more than 5 mm in size. Using the aforementioned arthroscopic portals, loose bodies were removed with arthroscopic techniques including graspers and the motorized shaver." I am of view that as per NCCI Edits Policy Manual Chapter IV discussed above the significant procedure of "removal of loose bodies" performed in lateral compartment is separately reportable under Code G0289 along with Code 29881. 10.In view of foregoing, it is clear that rather than billed Code 29874, CPT code G0289 is the proper code to report the procedure of 'removal of loose bodies' performed in lateral compartment separately, along with the Code 29881 reported for significant procedures of "meniscectomy" performed in medial compartments of knee joint. 11.It is pertinent to note that Respondent's fee coder has failed to provide any explanation why the billed Code 29874 should not be cross walked to the proper Code G0289 that can be separately billed along with Code 29881. I am of view that instead of straight away denying payment for the procedures that was medically necessary and appropriately documented in the operative report, merely on the grounds of improper Code. For the reimbursement purpose the Respondent should have cross-walked the billed code 29874

to appropriate code G0289 that was supported by the operative report. Here, as discussed above, the Operative report indicated that while procedure of "menicectomy" reported under Code 29881 was performed only in medial compartments. The significant procedure of "removal of loose bodies" was performed in lateral compartment as well. I am therefore of the opinion that as discussed above per operative report the procedures were performed in separate areas of the knee as recognized by NCCI Edits and AAOS, are distinct procedures from each other. Hence payment for code 29881 should not influence the billing of CPT code G0289. It is pertinent to note that I have not been provided with any verification request by the Respondent seeking additional verification as to the code reported and the rate billed by the Applicant for the procedure at issue. I am therefore of the opinion that, since CPT code 29874 which was billed by error, should be is the proper code to report the procedure of labrum tear repair performed in this case, therefore, there should not be any problem to cross walk billed code 29874 that was billed in error to proper code G0289 instead of denying payment to eligible services performed at issue. Thus, the Codes for consideration are 29881 and G0289. Go289 should be reimbursed at $5,596.40

Here, Operative report indicated that procedure of "Coblation Arthroplasty" under CPT code 29999 was performed in Patellofemoral compartments. Whereas, procedure of "Meniscectomies" reported under CPT 29881 was performed only in "Medial compartment". As such, per the documentation the procedures under codes 29999 were significantly distinct procedures from the procedure reported under code 29881 and hence not consolidated, but are payable separately. Therefore, the ASC fee payable to the Applicant for services performed on DOS at issue, as per EAPG methodology adopted by NY WC Fee Schedule is as under: CPT Code EAPG Group EAPG Rate Amount Payable Remark 29874-LT cross walk to G0289-LT 38 $5596.40 $5,596.40 Highest valued group payable at 100% of EAPG Rate 29881-59 37 $2944.87 $1,472.45 Additional procedure in separate compartment payable at 50% of EAPG Rate, and NCCI Edits do not billing of Codes 29881 with code G0289 29999-59 37 $2944.87 $1,472.45 Additional procedure in separate compartment payable at 50% of EAPG Rate, and NCCI Edits do not bar billing of Code 29999 with code 29881. 29884 37 $2944.87 $0.00 Per NCCI Edits not separately payable along with code 29881 29875 29876 20610 49 $473.39 $0.00 $81.37 Capital Add-on for ASC facility TOTAL $8,622.65

In conclusion, EOB indicated Respondent has paid the bill partially at $3,026.24. Therefore, the Applicant is entitled for additional amount of $5,596.43 ($8,622.65-$3,026.24), towards the ASC's fees for knee surgical procedures performed on DOS 07/30/2022 at issue.

After reviewing the totality of the credible and admissible evidence, hearing the arguments of the parties I find that the Respondent has sustained its burden of proof.

I am persuaded by the affidavit of Ms. Neve that the use of modifier 59 was not appropriate. Ms. Neve's opinion was supported by reference to CMS and NCCI documents, which I find persuasive authorities.. Under the NCCI guidelines, the knee is considered a single anatomical structure and therefore the additional procedures performed cannot be billed when performed on the same shoulder. Therefore, I find Ms. Neve's analysis regarding modifier 59 persuasive. Despite the number of incisions made

during the surgery, the procedures billed were performed on the same day and in the same anatomical site, the rights shoulder. I also find Applicant's position of changing the code after it was submitted reviewed and paid to be improper. Applicant is bound by the codes it billed under.

Accordingly, in light of the foregoing, based on the arguments of the parties representatives and after a thorough review of all submissions, I find in favor of Respondent and deny Applicant's claim.

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

09/28/2023
(Dated)

Stacey Erdheim

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:
2c5fb4ae049b9e62483a1cec2dc78f62

Electronically Signed

Your name: Stacey Erdheim
Signed on: 09/28/2023