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.	17-22-1275-4058
	Applicant's File No.	TLD22-1016019
	Insurer's Claim File No.	22-5691655
- and -	NAIC No.	14800
Progressive Casualty 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

   Kevin Darcy from Thwaites, Lundgren & D'Arcy Esqs participated virtually for the Applicant

   Courtney Mckeon from Progressive Casualty Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$14,776.33**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The record reveals that Claimant (AS) was involved in a motor vehicle accident on 5/26/22. Applicant seeks the balance of the services rendered on 6/29/22 in the amended amount of $3229.34. 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 (AS) was involved in a motor vehicle accident on 5/26/22. Applicant seeks the balance of the services rendered on 6/29/22 in the amended amount of $3229.34. 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 (AS) was involved in a motor vehicle accident on 5/26/22. Applicant seeks the balance of the services rendered on 6/29/22 in the amended amount of $3229.34. 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*).

With respect to the anesthesia bill in the reduced amount of $334.57, I agree with Applicant. Based on Respondent's own coder they under paid. With respect to the second anesthesia code, Respondent should have utilized a Peer Review to determine that the code used was not performed. Applicant is entitled to $334.57.

With respect to the facility fee, Respondent acknowledges that they owe Applicant $1422.33 as per their own coder's affidavit by Karen McCauley.

> Applicant submitted a claim for medical services allegedly rendered on **June 29, 2022.** Claim was for an Arthroscopy procedure and used CPT Codes 29880; 29884-59; 29874-59; 29876-59; 29875-59; 29999-59; 20610-59; the provider billed a total of $16,045.67 for this bill. 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 $3,026.24.
>
> The CMS document that addresses CPT's definition of the uses of modifier -59 does indicate that 'separate incisions' *are* a potential qualifier for the use of modifier -59. The document does, however, go on to further explain/clarify this. Page 3 of the CMS document [attached] gives a clear example regarding shoulder arthroscopies, it states, "Arthroscopic treatment of structures in adjoining areas of the same shoulder constitutes treatment of a single anatomic site."
>
> It would seem to be the most comprehensive argument to say that since multiple incisions were made the modifier was appropriate, however when the arthroscopic procedure is performed on the *same knee* in the *same* session, it would not be a factor to append modifier -59.
>
> Further, as noted in the CMS document (#6), "CPT code 29827 (arthroscopy, shoulder surgical; with rotator cuff repair); 29820 (arthroscopy, shoulder; surgical; synovectomy, partial)," - billed as an example of arthroscopy codes - "CPT code 29820 should not be reported and modifier -59 should not be used if both procedures are performed on the same shoulder during the same operative session because the shoulder joint is a single anatomic structure. If the procedures are performed on different shoulders, modifiers RT and LT should be used, not modifier -59." Again, the CMS example is for the shoulder, the same modifier 59 guidelines would apply to the knee. The National Correct Coding Initiative Edits (NCCI Edits), adopted by Medicare and Medicaid, limits the use of modifier -59 when applied in the context of Arthroscopy. Chapter IV, Surgery: Musculoskeletal System, CPT Codes 20000-29999. Section E (5) reads in part " ... With the exception of the knee and shoulder, arthroscopic debridement shall not be reported separately with a surgical arthroscopy procedure when performed on the same joint at the same patient encounter. For knee arthroscopic debridement see the following subsection (6) *CPT codes 29874 (Surgical knee arthroscopy for removal of loose body or foreign body) and 29877 (Surgical knee arthroscopy for debridementlshaving of articular cartilage) shall not be reported with other knee arthroscopy codes (29866-29889). With two exceptions HCPCS code G0289 may be reported with other knee*

arthroscopy codes. Since CPT codes 29880 and 29881 include debridement/shaving of articular cartilage of any compartment, HCPCS code G0289 may be reported with CPT codes 29880 or 29881 only if reported for removal of a loose body or foreign body from a different compartment of the same knee. HCPCS code G0289 shall not be reported for removal of a loose body or foreign body or debridementlshaving of articular cartilage from the same compartment as another knee arthroscopic procedure. For knee arthroscopic (8) *Arthroscopic synovectomy of the knee may be reported with CPT codes 29875 or 29876. A synovectomy to "clean up" a joint on which another more extensive procedure is performed is not separately reportable. CPT code 29875 shall not be reported with another arthroscopic knee procedure on the ipsilateral knee. CPT code 29876 may be reported for a medically reasonable and necessary synovectomy with another arthroscopic knee procedure on the ipsilateral knee if the synovectomy is performed in two compartments on which another arthroscopic procedure is not performed. For example CPT code 29876 shall not be reported for a major synovectomy with CPT code 29880 (knee arthroscopy, medial and lateral Meniscectomy) on the ipsilateral knee since knee arthroscopic procedures other than synovectomy are performed in two of the three knee compartments* CPT codes 29884, 29874, 29876, 29875, 29999, 20610 does not meet the exceptions above, therefore modifier -59 is not appropriate.

As set forth in the implementation guide " ... Significant procedure consolidation referto the collapsing of multiple related significant procedure APGs into a single APG for the purpose of determining payment.... " Review of the EAPG Schedules in the 3M APG Crosswalk database assigns CPT Codes 29880, 29884, 29874, 29876, 29875, 29999 to APG Group 37, CPT code 20610 to APG Group 49. The application of the predetermined weight, discounts, rate, and capital add on result in CPT Code 29880 being compensated in the amount of $3,026.24.

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.

Respondent's coder allowed Code 29880 at amount of $3,026.24 (100% of EAPG rate 2944.87 plus capital add-on of $81.37); and denied reimbursement for rest all billed codes. I am of opinion that the procedures reported under Code 29884, 29875, 29874, 29876 and 20610 are incidental to the procedures reported under code 29880 since the operative report indicated that both these procedures were performed in same compartment that is medial and lateral compartment of the knee joint. Although applicant has appended modifier 59 to Code 29884, 29875, 29874, 29876 and 20610, however the modifier is not supported by the operative report and hence these Codes are not separately payable. However, I disagree with denial of Code 29999 since the additional procedure reported under Code 29999 are performed in Patellofemoral compartment, that is, separate compartment of the knee joint and hence was significantly distinct procedures from the procedure reported under Code 29880, and

hence were not consolidated. I am of opinion that as per EAPG methodology and NCCI Edits, the Applicant is entitled to separate reimbursement for Code 29999 along with Code 29880 for the reasons discussed below: A. As per EAPG methodology only significant procedures that are an integral part of the primary significant procedure and which can be performed with relative little additional efforts when performed with primary procedures are consolidated. However, additional distinct significant procedure furnished in the same operative session are not consolidated in the APG classification system, but payment for additional unrelated significant procedure will be discounted at 50% of the applicable group price. B. Here, Respondent's coder has failed to discuss the operative report, to determine whether the procedure reported under code 29999 performed in separate knee compartment, is incidental to the significant procedure reported under coder 29880, or are additional significant procedures. The coder has simply denied these codes on the ground of consolidation logic without providing any explanation thereof, as such the denial is improper. C. Operative report indicated while the primary procedure of "Meniscectomy" reported under Code 29880 was performed in Medial and Lateral Compartments; the surgeon has performed additional procedures of "Coblation Arthroplasty", using the RF ArthroCare wand, down to a stable surface the unstable margins of patella and trochlea in the Patellofemoral Compartment. Thus, operative report supports the separate billing of additional distinct procedure of "coblation arthroplasty" under BR code 29999 performed in Patellofemoral compartment, that is, the separate compartment of the knee joint. The Operative report at relevant part has discussed these procedures in detail "The articular surface of the patella revealed a Grade II chondral lesion. The shaver followed by RF device were used to perform coblation arthroplasty of the patella debriding only the unstable areas. Extreme care was taken to avoid damaging the adjacent chondral surfaces...The articular surface of the trochlea revealed a Grade II chondral lesion. The shaver followed by RF device were used to perform coblation arthroplasty of the trochlea debriding only the unstable areas. Extreme care was taken to avoid damaging the adjacent chondral surfaces." Thus, the Operative Report has clearly demonstrated that the procedure performed was coblation arthroplasty and not simple chondroplasty that would be bundled up in procedure reported under code 29880. These procedures are billed under the unlisted code of 29999 because of the way the cartilage is treated. In this procedure, a radiofrequency wand is inserted into the joint and a current is passed within the tip of the wand to create plasma and it gets very hot and is then used to melt the cartilage, but without tissue damage. The BR code of 29999 is the proper code to report coblation procedure, as there is no other proper listed code to report it. D. Furthermore, there is nothing to indicate that procedures of 'Coblation Arthroplasty" (code 29999) performed in separate compartment, require minimal additional time or resources, and can be performed with relatively little additional effort when performed along with primary procedure of "menicectomy" reported under code 29880. E. Respondent has also not submitted any expert medical evidence such as peer review report to support its coder's opinion that the procedures of "coblation arthroplasty performed in "Patellofemoral compartment of the knee joint" reported under Code 29999 is included in "meniscectomy' procedures performed in "medial and lateral compartments" reported under code 29880. Absent a valid and reliable medical opinion, Respondent's coder opinion on bundling of the procedures performed is not reliable at all. Therefore, the ASC fee payable to Applicant per EAPG methodology adopted by NY WC Fee Schedule for the services at issue is as under: CPT Code EAPG code EAPG Rate

Payable Remark 29880-RT 37 $2944.87 $3,026.24 Primary procedure payable at 100% of EAPG rate plus Capital Add-on Payment of $81.37 29999-59 37 $2944.87 $1,472.44 Distinct significant procedure performed in separate compartment, payable at 50% of the EAPG rate Page No: 12 AAA#: 17-22-1275-4058 Patient: Anneudys Sierra DOL: 05/26/2022 DOS: 06/29/2022 29884 37 $2944.87 $0.00 Per NCCI Edits not separately payable. 29875 29874 29876 20610 49 $473.39 $0.00 Total $4,498.68 11.In conclusion, Applicant is entitled to total amount of $4,498.68, contrary to the recommendations of $3,026.24 done by respondent's fee coder towards ASC fee for knee surgical procedures performed on 06/29/2022.

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. McCauley that the use of modifier 59 was not appropriate. Ms. McCauley'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. McCauley'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. However Applicant is entitled to $1422.33 as per Ms. McCauley

Accordingly, in light of the foregoing, based on the arguments of the representatives and after a thorough review of all submissions, I find in favor of Applicant for $1756.90.

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
	Uptown Healthcare Management Inc d/b/a ETM- ACS Ambulatory Surgery Center of East Tremont	**06/29/22 - 06/29/22**	**$14,441.76**	**$2,894.77**	**Awarded: $1,422.33**
	Uptown Healthcare Management Inc d/b/a ETM- ACS Ambulatory Surgery Center of East Tremont	**06/29/22 - 06/29/22**	**$334.57**		**Awarded: $334.57**
Total			**$14,776.33**		**Awarded: $1,756.90**

B. The insurer shall also compute and pay the applicant interest set forth below. 11/18/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Since the claim arose from an accident that occurred on or after April 5, 2002, interest shall be paid, at the rate of 2% per month, simple, from the arbitration filing date 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

The insurer shall pay the applicant an attorney's fee, in accordance with 11 NYCRR 65-4.6. However, if the benefits and interest awarded thereon is equal to or less than the

respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6

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, 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:
0b167c4f0b0962052c5f456f07433d79

Electronically Signed

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