

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Hackensack Surgery Center LLC  
(Applicant)

- and -

State Farm Mutual Automobile Insurance  
Company  
(Respondent)

AAA Case No. 17-23-1286-1017

Applicant's File No. 3118808

Insurer's Claim File No. 52-40M7-91T

NAIC No. 25178

**ARBITRATION AWARD**

I, Victor Moritz, 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: IP

1. Hearing(s) held on 11/22/2023  
Declared closed by the arbitrator on 11/22/2023

Andrew J. Costella, Esq. from Law Offices of Andrew J. Costella Jr., Esq. participated virtually for the Applicant

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

2. The amount claimed in the Arbitration Request, **\$14,888.48**, 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

The applicant seeks additional reimbursement for the facility fee costs related to a right shoulder arthroscopic procedure provided to the IP (J.R. 34 year old female) on November 30, 2022, relative to a September 30, 2022, motor vehicle accident. The sole issue before me concerns the rate of reimbursement for the services rendered. The respondent has submitted a coding affidavit in support of their findings by Becky Lynn Neve, CPC. The applicant has also submitted an affidavit in support of a higher rate of reimbursement by Iwona Okrasinska, CFC. Ms. Neve provided a response to the

applicant's coding submission. This matter is determined after reviewing the submissions and presentations of both sides. I have reviewed the documents contained in the electronic case folder as of the closing of the file. The hearing was held on Zoom.

#### 4. Findings, Conclusions, and Basis Therefor

**I find for the respondent and deny this claim in its entirety.**

#### **Underlying Claim**

The IP, a resident of New York State, and the shoulder arthroscopy was performed in Hackensack, New Jersey, and the Ambulatory Surgical Center (ASC) provider billed the sum of \$19,387.17 and was reimbursed the sum of \$4,498.69, leaving \$14,888.48 in dispute.

In this case, the IP received an arthroscopy shoulder surgical synovectomy (partial) billed per CPT Code 29820; CPT Code 29823 arthroscopy shoulder surgical debridement extensive, and finally, CPT Code 29826, arthroscopy shoulder surgical decompression of subacromial space with partial acromioplasty with coracoacromial ligament release.

For this service, the provider billed CPT Code 29823 at \$6,462.39 and was reimbursed the sum of \$3,026.24. The applicant billed CPT Code 29826 with modifier 59 at \$6,462.39 and was reimbursed \$1,472.45. Finally, they billed CPT Code 29820 - modifier 59 at \$6,462.39, and no payment was made for that portion of the procedure. The basis of the reductions was the applicable fee schedule regulations.

While the applicant's claim seeks \$14,888.48, a review of this record, including the affidavit of CPC Okrasinska on behalf of the provider, establishes the applicant provider is seeking only \$1472.45 for reimbursement of CPT code 29820.

#### **Procedural Issue**

Initially, the applicant argued the respondent's explanation of benefits pertaining to CPT code 29820 is defective, noting that CPT Code 29820 - modifier 59 was mistakenly left out in the explanation of benefits.

I acknowledge the specific Code Item 29820 was left blank on the line item identifying this procedure; however, the amount at issue was noted, and, in this instance, the applicant billed three procedure codes and the other two are listed.

A basic tenet of New York No-Fault law indeed is that a denial must promptly apprise the claimant with a high degree of specificity of the grounds on which the disclaimer is

predicated. General Accident Insurance Group v. Cirucci, 46 N.Y.2d 862, (1979); see also, Nyack Hospital v. State Farm Mutual Auto Insurance Company, 11 A.D. 3d. 664 (2d Dept., 2004).

Notwithstanding, it is also true that factual discrepancies contained in the insurer's denial of claim form does not invalidate the denial where the denial is not complete or vague and does not otherwise involve a defense which has no merit as a matter of law, Westchester Medical Center v. Nationwide Mutual Insurance Co., 78 A.D. 3d 1168 (2d Dept. 2010). Non-prejudicial mistakes or omissions in the otherwise timely and proper denial of claim form are not necessarily fatal. See NYU-Hospital of Joint Diseases v. Allstate Insurance Co., 123 A.D. 3d 781 (2d Dept. 2014).

A non-substantive technical defect on the denial of claim form regarding the date requested verification is received does not affect the form's validity. See First Care Medical Equipment, LLC v. Kemper Ins. Co., 69 Misc 3d 139 (A), 2020 NY Slip Op 51326 (U) (App. Term, 2d., 11th and 13<sup>th</sup>, Dists.,

In this case, the denial is specific enough as three line items were performed and are identified on the explanation of benefits and the specific CPT codes 29823 and 29826 are listed; therefore, the line item that was left blank but did have a coding explanation was CPT code 29820 and I find the denial is not defective.

### **Fee Schedule**

The defendant has the burden to come forward with competent evidentiary proof to support its fee schedule defenses. Robert Physical Therapy, P.C. v. State Farm Mut. Auto. Ins. Co., 13 Misc. 3d. 172(Civ. Ct. Kings Co. 2006). A lay person is not qualified to evaluate the CPT codes or to change if the code is used by a health provider in its bills. See Abraham v. Country-Wide Ins. Co., 3 Misc. 3d. 130A (App. Term 2d. Dept. 2004). When a defendant fails to demonstrate by competent evidentiary proof that a plaintiff's claim was in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedule cannot be sustained. Continental Medical, P.C. v. Travels Indemnity Co., 11 Misc. 3d.145A (App. Term 1st Dept. 2006).

While amended Regulations section 65-3.8(g)(1) states proof of the fact, and amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances: ... (ii) for those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers; I do not believe the amended regulations were put into effect to shift the burden from the respondent to establish that a charge submitted by the applicant was above fee schedule. To do so would be to erode the holding in Viviane Etienne Med. Care v Country-Wide Ins. Co. 25 NY3d 498, 501 (2015) and to de facto require the applicant to establish the fee schedule for the service provided as an element of their prima facie case. I believe the regulations were put into effect to prevent an applicant from receiving

reimbursement for a service provided at a rate clearly in excess of the fee schedule where the respondent issued an untimely or even failed to issue any denial for the service.

Notwithstanding, if an insurer presents sufficient evidence to substantiate its reduction of a bill pursuant to the Workers' Compensation Medical Fee Schedule, the burden shifts to the medical provider to rebut the carrier's fee schedule interpretation, see, Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc. 3d 132A (App Term 1st Dep't 2011).

In addition, the 33rd Amendment went into effect on 01-23-18, subsequent to the date the procedure herein was performed and it pertains to health services performed outside New York State **on** or after that date (emphasis added).

As a result of the Amendment, 11 NYCRR §68.6 was modified and currently reads as follows:

(a)(1) If a professional health service reimbursable under Insurance Law 5102 (a)(1) is performed outside this State, the amount that the insurer shall reimburse for the service shall be the lower of the amount charged by the provider and the prevailing fee in the geographic location of the provider with respect to services:

(i) that constitute emergency care;

(ii) provided to an eligible injured person that is not a resident of this State; or

(iii) provided to an eligible injured person that is a resident of this State who, at the time of treatment, is residing in the jurisdiction where the treatment is being rendered for reasons unrelated to the treatment....

(b) Except as provided in subdivision (a) of this section, if a professional health service reimbursable under Insurance Law section 5102 (a)(1) is performed outside this State with respect to an eligible injured person that is a resident of this State, the amount that the insurer shall reimburse for the service shall be the lowest of:

(1) the amount of the fee set forth in the region of this State that has the highest applicable amount in the fee schedule for that service;

(2) the amount charged by the provider; and

(3) the prevailing fee in the geographic location of the provider.

(c) If the jurisdiction in which the treatment is being rendered has established a fee schedule for reimbursing health services rendered in connection with claims for motor vehicle-related injuries and the fee schedule applies to the service being provided, the prevailing fee amount specified in subdivisions (a) and (b) of this section shall be the amount prescribed in that jurisdiction's fee schedule for the respective service.

Under these circumstances, the applicant is seeking reimbursement for medical services rendered under a New York State Automobile Insurance policy provided to the IP, a resident of Middletown, New York, by an entity located in New Jersey.

Therefore, reimbursement is limited to **the lesser amount allowed** (emphasis added) under the prevailing rate for the geographic location of the Provider, the amount billed by the Provider or the highest amount allowable under the New York State Workers' Compensation fee schedule.

In support of the respondent's position, they have provided coding affidavits from Ms. Neve, attesting to his credentials and knowledge of the New York State Workers' Compensation Regulations and Rules. As indicated per the regulations, health service charges may not exceed the permissible amounts under the New York State Workers' Compensation fee schedule for accidents. The New York State Workers' Compensation ambulatory surgical fee schedule and prices are taken from the New York Health Rules. Effective October 1, 2015 the new enhanced ambulatory patient groups (EAPG) fee schedules apply to ambulatory surgical centers and hospitals. Further, payment for the ambulatory surgery services are made according to ambulatory patient groups (APG) methodology. Reimbursement for license fee standing ambulatory surgical centers and hospital-based ambulatory surgical services are set by the Workers' Compensation Board.

Ms. Neve identifies each of the three billed codes and indicates that under New York law, reimbursement is limited to \$3,026.24, while under New Jersey, the proper reimbursement rate was \$12,924.79. Therefore, as the lowest rate is applicable, reimbursement should have been made at \$3,026.24 and the provider was reimbursed above the applicable limit.

Specifically, Ms. Neve states:

*Modifiers 59 or -XS are for surgical procedures that are performed at different anatomic sites, aren't ordinarily performed or encountered on the same day. The definition of different anatomic sites includes different organs. The treatment of contiguous structures in the same organ or anatomic region generally does not constitute treatment of different anatomic sites. Modifier 59 would be used appropriately for surgical procedures performed during different patient encounters on the same day.*

*One of the common misuses of modifier 59 relates to the part of the definition of modifier 59 allowing its use to describe a "different procedure or surgery." Don't report the codes together if performed at the same anatomic site and same patient encounter, because they aren't considered "separate and distinct." If you perform 2 procedures at separate anatomic sites or at separate patient encounters on the same date of service, you may use modifier 59.*

Additional information regarding the use of modifier is provided in Medicare NCCI edits: *Modifier 59 is an important NCCI PTP-associated modifier that is often used incorrectly. For the NCCI program, its primary purpose is to indicate that 2 or more procedures are performed at different anatomic sites or different patient encounters."*

*Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass a PTP edit unless the proper criteria for use of the modifier are met.*

*Modifier 59 or XS is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions.*

Medicare NCCI General Correct Coding Policies, Chapter IV-6 (4) (hereinto, See Exhibit O) specifically addresses arthroscopy procedures. "The NCCI program considers the shoulder to be a single anatomic structure."

*An NCCI PTP edit code pair consisting of two codes describing two shoulder arthroscopy procedures shall not be bypassed with an NCCI PTP-associated modifier when the procedures are performed on the ipsilateral shoulder." (ipsilateral is defined as occurring on the same side) This type of edit may be bypassed with an NCCI PTP-associated modifier only if the two procedures are performed on contralateral shoulders. (contralateral is defined as occurring on opposite sides).*

CPT code 29823 is used to report "Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structure". The operative report supports this code as billed.

CPT code 29820 is used to report "Arthroscopy, shoulder, surgical; synovectomy, limited". The operative report supports this code but does not support modifier 59.

CPT code 29826 was reported for "Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure). The documentation supports this code but does not support the use of modifier 59.

*CPT 29826 is designated as an add-on code by the AMA in CPT and this code is separately reportable. Although separately reportable, this does not equate to separate reimbursement for the facility under the EAPG payment methodology. Under the EAPG payment methodology, reimbursement is NOT based on the RVU's of a CPT code, but rather on the APG group that code is assigned to. What this means is that while a physician billing this service may be reimbursed, the facility may not be.*

*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 shoulder through the same portals at the same encounter.*

*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 29823), 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.*

*The NCCI and 3M Proprietary EAPG edits apply for the services in question on this bill. NCCI edits are present for the code combinations of 29823/29820. The 3M proprietary edit (same EAPG consolidation) is present for the code combination 29823/29826. All reported CPT codes 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.*

*Further, using Surgery Ground Rule 7 is not appropriate. The Surgery Ground Rule is contained in the New York Workers' Compensation Medical Fee Schedule, which is applicable to physician billing. This is a facility bill, and the reimbursement methodology utilized by the State of New York is the EAPG Payment Methodology. The EAPG methodology does not incorporate the Workers' Compensation Medical Fee Schedule.*

*Utilizing the applicable methodology, Ms. Neve opines 29820 is not eligible for reimbursement based on two separate reasons. The first being the NCCI PTP edits. The second being same APG consolidation.*

*Applying the 3M software, Ms. Neve notes that the proper EAPG group code for CPT Code 29823 is Group 37 utilizing the calculated formulas and allows for a base payment of \$2,944.87 with an add-on payment of \$81.37, allowing for \$3,026.24. Both of the other procedures would also be in the same EAPG group.*

*While 29820 is supported to be billed. ... The APG Provider manual states that NCCI edits apply and APG Grouping logic consolidates related significant procedures. The 3M software contains the logic to perform these actions. It is the 3M software that indicated there was no payment for 29820 based on NCCI edits. When coded based on the operative report, .... Modifier 59 is not be supported because all services were performed to the same anatomic site (shoulder) at the same operative session.*

*29820 is not payable based on a Center for Medicare and Medicaid Services (CMS) Procedure to Procedure (PTP) Coding Edit. 29823 is identified in Column 1 and 29820 in Column 2. While the "1" indicates that a modifier is allowed one of the core fundamental rules of coding is that documentation MUST support the use of the modifier. Just because it is allowed to be used on the column 2 code, does not mean it is*

*supported. A modifier is not supported because all services were performed to the same anatomic site at the same operative session. The 3M software does not allow separate reimbursement for this code based on the NCCI Procedure-to-procedure code edits.*

Ms. Neve opines that CPT code 29826 should not have been reimbursed. *When multiple procedures map to the same APG, the additional occurrences (beyond the first) will consolidate. In the EAPG methodology, the EAPG categories are a classification system designed to provide payment based on the type and amount of resources used during an encounter. Consolidation refers to the process of combining or collapsing related services into a primary APG to arrive at a payment.*

Thus, reimbursement should have been limited to \$3026.24 per CPT code 29823 and the provider was overpaid for their services.

In opposition, I note the affidavit from Ms. Okrasinska, billing manager for the provider, noting the mistake concerning the affidavit, failing to list CPT Code 29820, and that CPT Code 29820 should have been reimbursed at fifty percent of the EAPG value, for this service at \$1,472.45, discussing the proper and allowable usage of modifier 59 two codes being different procedures/ surgeries.

*For anatomic sites or at separate patient encounters on the same date of service, modifier 59 should be appended to indicate that they are different procedures/surgeries on that date of service. Continuing... Arthroscopic treatment of structures in adjoining areas of the same shoulder constitutes treatment of a single anatomic site." In this scenario, indeed the number of incisions/ excision and/or surgical portals that are NOT common with an arthroscopic procedure on the shoulder, it is explained that modifier -59 would be appropriate. Separate incisions are NOT an inherent part of arthroscopic procedures. NCCI established coding edits to determine if two codes may/may not be billed together. It is correct if there is no edit between codes, they may be billed together. The modifier -59 criteria outlined was indeed met, ergo the modifier is proper for facility billing. This coding decision involves two separate and distinct processes: first may the codes be billed together (no coding edit), the second, if yes, can/should modifier -59 be applied. In this instant matter, not only are there coding edits between the codes billed, but also since the procedures are inherently separate surgical procedures requiring multiple incisions/ excisions/surgical portals during the surgery, the modifier is proper.*

*Furthermore, our office correctly appended 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. The NCCI edits also outline the exceptions when multiple arthroscopic procedures are performed on the same shoulder would be entitled to separate reimbursement, and based on the documentation submitted, the CPT codes at issue unequivocally meet the criteria for qualified payable exceptions, therefore, modifier -59 is appropriate for these services.*

### **Conclusions**

In the instant matter, I find for the respondent and deny the claim.

While the applicant did not reduce this claim, a review of the competing affidavit appears to indicate the only amount that would be at issue would be whether or not the provider should be reimbursed at fifty percent of the applicable Fee Schedule for CPT



Code 29820. The applicant's own affidavit acknowledges that if reimbursement was to be made, it should have been billed at the above-listed amount.

In support of the respondent's position, Ms. Neve stated "29820 is not eligible for reimbursement based on two separate reasons. The first being the NCCI PTP edits. The second being same APG consolidation."

Further, the provider indicating the service is reimbursable per Surgery Ground Rule 7 is improper. Ms. Neve states, "the Surgery Ground Rule is contained in the New York Workers' Compensation Medical Fee Schedule, which is applicable to physician billing. This is a facility bill, and the reimbursement methodology utilized by the State of New York is the EAPG Payment Methodology. The EAPG methodology does not incorporate the Workers' Compensation Medical Fee Schedule."

In this case, I accept the analysis from Ms. Neve that additional reimbursement per CPT Code 29820 and CPT Code 29826 was improper.

In sum, the provider was reimbursed above the applicable rate for these services and no additional amounts are owed.

**Accordingly, the claim is denied in its entirety.**

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 Westchester

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

12/13/2023

(Dated)

Victor Moritz

### **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:**  
dc1c6b8151de10d33d48fea00dc6328f

### **Electronically Signed**

Your name: Victor Moritz  
Signed on: 12/13/2023