

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

North Shore Surgi Center  
(Applicant)

- and -

Esurance Insurance Company  
(Respondent)

AAA Case No. 17-24-1339-8354

Applicant's File No. NF 3746506

Insurer's Claim File No. NYA0213430

NAIC No. 30210

**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 08/22/2024  
Declared closed by the arbitrator on 08/22/2024

Vijay Gupta, Esq. from The Law Office of Thomas Tona, PC participated virtually for the Applicant

John Palatianos, Esq. from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$10,843.14**, 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 reimbursement for the Ambulatory Surgical Center (ASC) costs related to a left shoulder arthroscopic procedure provided to the IP (E.A. 37-year-old female) on April 7, 2022, relative to a September 2, 2021, motor vehicle accident. The respondent alleges that the bill was submitted above the fee schedule; however, no specific denial is part of the record. I acknowledge a coding affidavit from the respondent supporting a reduced amount for this service. 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 applicant and award \$3,026.24 for the ASC costs related to the left shoulder arthroscopy.**

I note that an arbitrator need not adhere with strict conformity to the evidentiary rules set forth in CPLR 2016 see Auto One Ins. Co., v Hillside Chiropractic P.C. 126 A.D. 3d. 423 (1<sup>st</sup> Dep't, 2015) citing 11 NYCRR 65-4.5 (o) the arbitrator shall be the judge of the relevance and materiality of the evidence offered. 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. Arbitrators sit in equity and have the powers to enforce the spirit and intent of the No-fault law and regulations Bd. of Education, et. al. v. Bellmore-Merrick 39 N.Y. 2d. 167 (1976).

#### **Submissions**

The applicant submitted the bill for the left shoulder arthroscopy in the amount of \$10,843.14 as follows: CPT Code 29821 at \$5,677.77; CPT Code 29823-modifier 59 at \$1,472.43; CPT Code 29826 at \$1,472.43; and CPT Code 23700-modifier 59 at \$748.08.

The respondent's submission does not include any specific denial to this claim, however, respondent has submitted a coding affidavit from Amanda Dix, a certified professional coder, discussing her licensing and credentials and that she is employed by Managed Network Inc. The respondent has provided an EOB for Managed Care Network Inc. indicating that the proper rate of reimbursement herein is \$3,026.24, noting as follows:

*Modifier 59: Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or the area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. Modifier 59 removed from codes 29823 and 29825. All surgical procedures performed on the same shoulder (left), in the same operative session, and are commonly performed together.*

*Code 23700 (Manipulation under anesthesia) it is inclusive by definition to 29825. Code 23700 is removed prior to grouping. 936- Code 29821 is not supported by the documentation. The documentation does not meet the criteria for a complete synovectomy. Therefore, code 29821 (synovectomy, complete) is changed to 29820 (synovectomy, partial). 5802- Significant procedure Consolidation (refers to the collapsing of multiple related significant procedure APG's into a single EAPG for the purpose of determining payment) based on the New York Enhanced Ambulatory Patient Grouping (EAPG) Methodology. 5805- These procedure codes have NCCI PTP edits with the primary significant procedure code 29823. 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. NCCI Policy Manual Chapter IV: E; 4. CMS*

*considers the shoulder to be a single anatomic structure. With three exceptions an NCCI procedure-to-procedure edit code pair consisting of two codes describing two shoulder arthroscopy procedures shall not be bypassed with an NCCI-associated modifier when the two procedures are performed on the ipsilateral shoulder. This type of edit may be bypassed with an NCCI-associated modifier only if the two procedures are performed on contralateral shoulders.*

## **Fee Schedule**

It is well settled that an applicant established its prima facie entitlement to payment by proving it submitted a claim set forth the facts and the amount of the loss sustained and that payment of no-fault benefits were overdue (see Insurance Law § 5106[a]; Viviane Etienne Med. Care v Country-Wide Ins. Co., 25 NY3d 498, 501 (2015); Countrywide Ins. Co. v. 563 Grand Medical PC 50 A.D. 3d. 313 (1<sup>st</sup> Dept., 2008); Sunshine Imaging Assoc./WNY MRI v. Geico. Ins. Co., 66 A.D. 3d. 1419 (4<sup>th</sup> Dept., 2009). A facially valid claim is presented when it sets forth the name of the patient; date of accident; date of the services; description of services rendered and the charges for those services. See Vinings Spinal Diagnostic PC v. Liberty Mutual Insurance Company, 186 Misc. 2d 287 (1<sup>st</sup> Dist. Ct. Nass. Co. 1996). The respondent has acknowledged receipt of this bill, therefore, the applicant has met this burden.

The defendant has the burden of coming 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 layperson is not qualified to evaluate the CPT codes or to change if a health provider's bills use the code. 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 Dept. 2011).

As stated above, the respondent has provided the coding affidavit from Amanda Dix in support of its position. The affidavit notes that the IP resides in New York State, and North Shore Surgi Center is located in Smithtown, NY (Downstate).

NYS No-Fault requires that payment of benefits shall be in accordance with the promulgated fee schedule. The fee schedule (FS) adopted by No-Fault is that established by the NYS Workers' Compensation Board (NYS Insurance Law §68.1).

*Applicant is an ambulatory surgery center (ASC) that provided ambulatory surgery facility services to Claimant on 04/07/2022. For ambulatory surgery facility payments, the NYS Workers' Compensation Board adopted Enhanced Ambulatory Patient Group (EAPG) reimbursement methodology effective for dates of service (DOS) beginning 10/1/2015. As the ASC facility services took place on 04/07/2022 which date is after 10/1/2015, EAPG reimbursement methodology applies to this ASC facility claim.*

*EAPG reimbursement utilizes 3M core grouping software with embedded Hospital Outpatient National Correct Coding Initiative (NCCI) Edits, Medically Unlikely Edits (MUEs) and 3M proprietary edits. These edits are integral to EAPG methodology and are expressly endorsed by the NYS WC Board, which states in the NYS WC Board EAPG Implementation Guide (MDO-EAPGImpGuide-1-v1 2-16): ". . . Hospital Outpatient NCCI edits, Medical Unlikely edits, and 3M Proprietary EAPG edits will be used by the Board. . . . These settings are necessary to properly calculate ambulatory surgery bills under the NYS workers' compensation system."*

*EAPG's categorize the amount and type of resources used in various ambulatory visits. Patients within each APG have similar resource use and cost. APG's group together procedures and medical visits that share similar characteristics and resource utilization patterns for payment purposes. EAPG reimburses based on patients' conditions and severity, and the grouper consolidates, discounts, and packages the cost of certain services in arriving at a single overall payment.*

*The EAPG grouper considers the type and location of the providing facility in its reimbursement logic. In this case, downstate ambulatory surgery rate data applies as North Shore Surgi Center is located in Suffolk County in the downstate rate region of New York (NYS Workers' Compensation Board EAPG Implementation Guide).*

*The applicant submitted several CPT codes for the ASC facility services on 04/07/2022 o 29821-LT (Arthroscopy, shoulder, surgical; synovectomy, complete) - (Left side).*

*29823- 59- LT (Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone,*

*glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])) - 59 (Distinct Procedural Service) - (Left side).*

*29825-59-LT (Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation)) - 59 (Distinct Procedural Service) - (Left side) o 29826-LT (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)) - (Left side) o 23700-59-LT (Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)- 59 (Distinct Procedural Service) - (Left side).*

*The record supports left shoulder arthroscopic surgery at the ASC facility.*

*CPT codes 29823 and 29825 were incorrectly reported with modifier 59 (Distinct Procedural Service). These procedures were all performed on the left shoulder, and therefore do not meet the criteria of a "Distinct Procedural Service".*

NY WC FS clarifies the use of this modifier. Ground Rule 20 (Modifiers), and the AMA's CPT Manual defines modifier 59 as follows: "Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

The CMS Medical Learning Network fact sheet Proper Use of Modifiers 59 & -X{EPSU} explains the proper use and inappropriate use of modifier 59:

*Don't use modifiers 59, -X{EPSU} and other NCCI PTP-associated modifiers to bypass an NCCI PTP edit unless the proper criteria for use of the modifiers are met. Medical documentation must satisfy the required criteria. o Using modifiers 59 or -XS properly for different anatomic sites during the same encounter only when procedures which aren't ordinarily performed or encountered on the same day are performed on: Different organs, or Different anatomic regions, or*

*In limited situations on different, non-contiguous lesions in different anatomic regions of the same organ Modifiers 59 or -XS are for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that: Are performed at different anatomic sites, Aren't ordinarily performed or encountered on the same day o Don't use modifiers 59 or*

*XU just because the code descriptors of the 2 codes are different. 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." The code descriptors of the 2 codes of a*

*code pair edit describe different procedures, even though they may overlap. Don't report the 2 codes together if they're performed at the same anatomic site and same patient encounter, because they aren't considered "separate and distinct."*

Don't use modifiers 59 or -XU to bypass a PTP edit based on the 2 codes being different procedures.

Continuing, "all of the procedures were performed on the same (left) shoulder, in the same operative session, by the same surgeon, and these procedures ARE commonly performed together. Therefore, clearly these procedures do not meet the NCCI, AMA, or NYS WCB requirements for appending modifier 59. Modifier 59 is removed from codes 29823 and 29825 prior to grouping."

*Code 23700 (Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded) is inclusive by AMA CPT definition to code 29825 (Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation). All procedures were performed on the left shoulder.*

*Therefore, code 23700 is removed prior to grouping as this code is inclusive to code 29825.*

*Code 29821 is changed to 29820 prior to grouping, Full Synovectomy is not supported.*

*In the grouper, CPT code 29823 was considered to be the significant procedure. It receives full EAPG payment plus a Capital Add-on amount.*

*The grouper found no assignment for codes 29820 and 29825 (APG 999 - Unassigned). This is consistent with NCCI edits on these codes when paired with 29823. As above, the NYS WC Board utilizes NCCI edits in EAPG methodology and states: "These settings are necessary to properly calculate ambulatory surgery bills under the NYS workers' compensation system."*

*The NYS WC EAPG grouper consolidated CPT Code 29826. This code was grouped to 37 LEVEL I ARTHROSCOPY. Per EAPG methodology and logic, the less extensive code is consolidated: o "Significant Procedure Consolidation: Significant procedure consolidation refers to the collapsing of multiple related significant procedure APGs into a single APG for the purpose of determining payment." And "Consolidation is the process for determining if a single payment amount is appropriate in those circumstances when a patient receives multiple APG procedures during a single visit."*

*APG-Relative weights are then determined for the services eligible for reimbursement and adjustments are made depending on reimbursement status and discount percentage or Payment Flag. - 29823 - 9.9509.*

*The NYS WCB EAPG Base Rates for Ambulatory Surgery performed in an Ambulatory Surgery Center in the downstate region is \$295.94 and Capital Add-On of \$81.37.*

*Reimbursement rates are calculated using the EAPG calculation:  $o\ 29823 = \$295.94$  (base rate)  $\times 9.9509$  (weight) +  $\$81.37$  (capital add-on) =  $\$3,026.24$ .*

*Though the NY WC EAPG logic and methodology may have no payment, package, or consolidate procedures with the significant procedure. That does not mean that the grouper does not recognize that the reported procedures were performed. These procedures are not denied, rather the APG system works by consolidating the procedures that have the same APG, it does not pay for procedures that have an NCCI edit with the significant procedure, or packages payment for procedures that are ancillary to the significant procedure and therefore are inclusive to payment for that procedure. The facility payment is structured to pay for the cost of resources, staff and equipment, not individual procedures as professional bills are. This is why the use of inappropriate modifiers to override or bypass the EAPG software's logic and methodology are prohibited by the NY WC FS and NCCI Policy and edits. The NCCI edits and EAPG grouper were put into place to stop overpayment by unbundling of codes, using incorrect modifiers to defeat this purpose is incorrect coding and reporting.*

Therefore, the maximum reimbursement under the NY WC FS for the procedure is \$3,026.24.

As acknowledged by the applicant, they have failed to provide any evidence to refute the determinations of the respondent's expert.

Further, though the carrier acknowledged the rate of reimbursement owed, the respondent acknowledged there is no indication that the amount was ever reimbursed to the provider or that a separate medical necessity defense was ever alleged.

**Under these circumstances, the claim is awarded for \$3,026.24.**

Finally, as there is no specific proof of mailing as to when the respondent received this bill, as the applicant's proof of mailing contains an envelope stating "return to sender., ..undeliverable", equity dictates that interest shall accrue from the filing of the AR-1 on March 12, 2024 through the payment of the 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 applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Status
	North Shore Surgi Center	04/07/22 - 04/07/22	\$10,843.14	Awarded: \$3,026.24
Total			\$10,843.14	Awarded: \$3,026.24

- B. The insurer shall also compute and pay the applicant interest set forth below. 03/12/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The respondent shall pay interest at a rate of two percent per month, simple on a pro rata basis using a thirty day month. With respect to the claim herein, interest will run from March 12, 2024, the date of the filing of this claim, through payment of the claim.

C. Attorney's Fees

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

As this matter was filed **after** February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with promulgated 11 NYCRR 65-4.6(d).

With respect to this claim, the applicant is entitled to attorney's fees for the medical services provided to the IP for which the applicant is awarded the sum of \$3026.24.



- 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 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.

08/28/2024

(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:**  
d9d8d80201e7c9102d932ec365b7164f

### Electronically Signed

Your name: Victor Moritz  
Signed on: 08/28/2024