American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Island Ambulatory Surgery Center LLC (Applicant)	AAA Case No.	17-24-1342-9197
	Applicant's File No.	00131137
- and -	Insurer's Claim File No.	235292576
	NAIC No.	24260
Progressive Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Rebecca Novak, 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: Assignor [''EH'']

1. Hearing(s) held on 09/03/2024
   Declared closed by the arbitrator on 09/03/2024

   Moneesh Bakshi, Esq. from Drachman Katz, LLP participated virtually for the Applicant

   Danielle Mazzola, Esq. from Progressive Casualty Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$15,889.93**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.
   The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bill and to the timeliness of Respondent's denial.

3. Summary of Issues in Dispute

   Whether Applicant established entitlement to No-Fault insurance compensation for a facility fee associated with a lumbar percutaneous discectomy and associated services, performed on January 25, 2024, to treat Assignor, a 50-year-old female, subsequent to being injured in a motor vehicle accident on September 30, 2023.

Whether Respondent's timely denial for the aforesaid facility fee performed on January 25, 2024, based on an independent medical exam ("IME") conducted by Dr. Stuart Hershon on November 27, 2023 with a cutoff date effective December 7, 2023, should be sustained.

Whether fees were not in accordance with fee schedule.

4. Findings, Conclusions, and Basis Therefor

In this No-Fault insurance arbitration, Applicant is seeking as compensation $15,889.93 for a facility fee associated with a lumbar percutaneous discectomy and associated services performed to treat Assignor, a 50-year-old female, on January 25, 2024, subsequent to being injured in a motor vehicle accident on September 30, 2023. Respondent denied payment of the bill at issue based on an independent medical exam ("IME") conducted by Dr. Stuart Hershon with a cutoff date of December 7, 2023.

Both parties appeared at the hearing via Zoom (Applicant by counsel, Respondent by claims representative), who presented oral argument and relied upon documentary submissions. I have reviewed the submissions' documents contained in the American Arbitration Association's ADR Center as of the date of the hearing, said submissions constituting the record in this case.

Stipulations were entered into at the hearing, amongst which were that Applicant established a prima facie case of entitlement of No-Fault compensation for the amount it sought and that Applicant's bill was timely denied by Respondent.

Assignor, a 50-year-old female, was a pedestrian struck by a motor vehicle while crossing the street on September 30, 2023. She did not lose consciousness but reportedly sustained injuries to her neck, lower back, left elbow, left wrist, and right knee. She was transported by ambulance to the Elmhurst Hospital Emergency Room where she underwent routine evaluation and x-rays and was released for outpatient care the same day. Assignor began a course of conservative treatment including physical therapy, acupuncture, and medication. She also underwent MRIs of the neck and arm. During the course of her treatment, she underwent a lumbar percutaneous discectomy on January 25, 2024. Applicant is now seeking reimbursement for the facility fee associated with those services.

Respondent denied reimbursement of the bill at issue based on an Independent Medical Exam ("IME") conducted by Dr. Stuart Hershon on on November 27, 2023 with a cutoff date effective December 7, 2023.

An IME doctor must establish a factual basis and medical rationale for his asserted lack of medical necessity of further health care services. E.g., Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), 2008 WL 4222084 (App. Term 2d & 11th Dists. Sept. 3, 2008). If he does so, it becomes incumbent on the claimant to

rebut the IME review, see AJS Chiropractic, P.C. v. Mercury Ins. Co., 2009 WL 323421 (App. Term 2d & 11th Dist. Feb. 9, 2002), because the ultimate burden of proof on the issue of medical necessity lies with the claimant. See Insurance Law § 5102.

"Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity (see Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11th ed])." West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 824 N.Y.S.2d 759 (Table), 2006 WL 2829826 (App. Term 2d & 11th Dists. Sept. 29, 2006).

In his IME report, Dr. Hershon listed the medical records which he reviewed and gave a brief history of the accident and Assignor's treatment. He then conducted an orthopedic examination of Assignor, measuring range of motion with a goniometer and cited as per the AMA Guidelines to the Evaluation of Permanent Impairment, Fifth Edition. At the time of the exam, Assignor claimed that she had complaints of pain in her neck, left elbow, and left hand. While Dr. Hershon examined the cervical, thoracic, and lumbar spine, the right and left shoulders, right and left elbows, right and left wrist/hand, right and left hips, right and left knee, and right and left ankle/foot, inasmuch as the service at issue was a lumbar percutaneous discectomy, the component of Dr. Hershon's examination which is relevant is that which is related to the lumbar spine.

Examination of all areas was unremarkable, with range of motion in all planes tested indicated as normal and all orthopedic tests conducted were negative. With regard to the lumbar spine, examination revealed no muscle spasm or tenderness, range of motion was normal, muscle strength, sensory examination, and all provocative orthopedic testing were normal. Based on his examination, Dr. Hershon determined that cervical spine sprain/strain was resolved; and left elbow, left hand/wrist, and left knee sprains/strains were resolved. He state that all other areas examined were unremarkable. Dr. Hershon determined that no further orthopedic treatment was medically necessary, and there was no need for further diagnostic testing, physical therapy, prescription medication, office visits, surgery, massage therapy, or other enumerated services.

I find that Dr. Hershon's IME report set forth an adequate factual basis and medical rationale. It established for Respondent a prima facie case in support of its IME cutoff that no further services were medically necessary. As per the case law cited to above, the burden shifted to Applicant to rebut the IME report.

To rebut the IME, Applicant relied upon the medical records it submitted, as well as a rebuttal by Dr. Marc Cohen, dated July 31, 2024. Dr. Cohn reviewed in detail the various evaluations of Assignor, including office visit reports and physical therapy notes, performed on October 17, 2023, October 19, 2023, October 24, 2023, October 25, 2023, and October 27, 2023, indicating Assignor's continued complaints of pain in the neck, mid back, lower back, left shoulder, and left knee, as well as restricted range of motion and positive findings.

Dr. Cohen noted that Dr. Hershon performed an orthopedic exam and not a pain management exam, and thus did not make a decision from a pain management viewpoint. He also pointed out that a lumbar MRI was performed on December 27, 2023, just four weeks after the date of the IME, which showed findings of multiple disc bulges, herniations, and nerve root impingement, indicative of radiculopathy. Dr. Cohen noted that since the MRI was performed after Dr. Hershon's IME, he was unable to review its results. Dr. Cohen contended that had he done so "he likely would have drawn a different conclusion regarding pain management treatment, as the clear positive results contained therein further support the medical necessity for further treatment."

Having carefully considered the submissions of the parties, the relevant case law and the arguments of respective counsel, I conclude that the preponderance of the credible evidence supports a finding in favor of Applicant, who has submitted sufficient evidence to refute Respondent's IME findings and hence its defense. To begin with, while I did determine that Dr. Hershon's IME report set forth an adequate factual basis and medical rationale to support the defense, I find it notable that he failed to make a diagnosis on the lumbar spine, stating only that the area examined was "unremarkable."

Furthermore, while it is true that Dr. Hershon's IME was negative, it is apparent that it was but one "snapshot in time." A person's condition can wax and wane, see Huntington Medical Plaza, P.C. v. Travelers Indemnity Co., 43 Misc.3d 129(A), 990 N.Y.S.2d 437 (Table), 2014 N.Y. Slip Op. 50527(U), 2014 WL 1344448 (App. Term 2d, 11 & 13th Dists. Mar. 21, 2014). I find that although Assignor was found not to have any disabilities on November 27, 2023, further treatment was still medically necessary for her condition, which had not yet resolved. I therefore find that Applicant's position prevails over Respondent's case for lack of medical necessity. I find that the Applicant's prima facie case for reimbursement stands.

There still remains the issue of the fees to be awarded.

Applicant billed CPT Code 62287 in the amount of $5,296.65, and Code 22526-59, 22527-XS 22527-59, and 22899-59, in the amounts of $2,648.32 each for a total of $13,241.61.

The subject surgical facility services are subject to the Workers' Compensation EAPG (Enhanced Ambulatory Payment Group) fee schedule. At the hearing, Respondent's counsel asserted that based on calculations using the EAPG methodology, Applicant overbilled.

Defendant has the burden to come forward with competent evidentiary proof to support its fee schedule defenses. Robert Physical Therapy PC v. State Farm Mutual Auto Ins.Co., 13 Misc.3d 172 (Civ. Ct. Kings Co. 2006). If an insurer presents sufficient evidence to substantiate its fee schedule calculation, the burden shifts to the medical provider to raise a triable issue of fact regarding the insurer's fee schedule interpretation. Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A), 2011 N.Y. Slip Op. 50040(U) (App. Term 1st Dept. Jan. 14, 2011).

In support of its defense, Respondent submitted an affidavit by Sarah Lindenauer, CPC, dated April 26, 2024, wherein she asserted that only code 62287 was reimbursable in the amount of $5,292.93, and the remaining codes were not separately reimbursable. The modifier 59 is used to signal services in a different session, a different procedure, a different site, a separate incision, a separate lesion, or a separate injury not usually associated or ordinarily encountered with the primary procedure. She stated as follows:

> The National Correct Coding Initiative Edits (NCCI Edits), adopted by the Medicare and Medicaid, limits the use of modifier -59. Chapter I, General Correct Coding Policies: Chapter I Section E Modifiers and Modifier Indicators (1) (d) Modifier 59 specifically describe proper usage of modifier 59. Bills and records submitted by the provider do not satisfy the requirements for usage of modifier 59. Specifically, the edits indicate that modifier 59 "*may be reported together when the two procedures are performed at different anatomic sites or different patient encounters*". Additional CMS further clarifies proper usage of modifier 59 in their article dated May 17, 2019. The procedures billed were performed at the same anatomic site and same patient encounter, therefore, the use of modifier 59 is not appropriate for CPT codes 22526, 22527, and 22899. Copies of relevant sections of the NCCI General Rules and Guidelines are attached at Exhibit "5".
>
> Since the operative report clearly states that both the discography/discogram (62287) and the annuloplasty (22526/22527) were performed at the same levels and in this instant matter, all codes are listed in APG 28, modifier -59 is not proper.
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> Code 62287 is for the discectomy - as well as the discography - codes 22526 and 22527 are the annuloplasty.
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> The provider billed modifier XS (separate organ/structure). Based on the operative report, the procedures billed were performed in the same organ/structure, therefore the use of modifier XS is not appropriate for CPT code 22527. Copies of relevant sections of the NCCI General Rules and Guidelines are attached at Exhibit "5".
>
> Regarding add-on Code 22527 - per the NCCI Introduction Policy Manual, "…if an edit prevents payment of the primary procedure code, the AOC (add-on code) shall not be paid." Since the primary code, 22526, is not eligible for payment, code 22527 would not be payable.
>
> Attached at Exhibit "8" is the "Policy and Billing Guidance Ambulatory Patient Groups (APGs) Provider Manual," which addresses billing and discounting procedures.
>
> Based on my review of the claim and the claim handling for the bills in dispute, the allowable fee schedule amount is $5,292.93 and the remainder of the claim should be dismissed as billed in excess of the Worker's Compensation Fee Schedule pursuant to 11 NYCRR 65-3.8 (g)(1)(ii) and 11 NYCRR 68.7.

In response to Respondent's fee coder and in support of it claim, Applicant relied upon a fee coder affidavit by Esther Tetro, CPC, dated August 19, 2024. Ms. Tetro conceded that codes 22527 and code 22899 were not separately reimbursable. However, she argued that code 62287 was reimbursable at $5,292.93 and code 22526-59 was reimbursable in the amount of $2,605.78 for a total of $7,898.71. In her affidavit, she stated:

> Upon review of the Operative Report, it clearly indicates that the discectomy was performed on the L4-5 level, while the annuloplasty was performed on levels L2-3, L4-L5 and LS-Sl, additional levels that the discectomy was not performed. The CPT considers different spinal levels to be separate anatomic sites. Please refer to the first paragraph of page 10 of NCCI Policy Manual attached. In the case at hand, the annuloplasty was clearly performed on additional levels of the spine that the discectomy was not so it would qualify for reimbursement.

After my review of both affidavits, I am more persuaded by Respondent's position. I find that Respondent's affidavit was more compelling and her analysis provided a more substantive understanding of the issues. Ms. Tetro failed to establish that different levels in the lumbar spine would be considered a different surgery, site or incision. All procedures were performed to the lumbar spine at the same encounter by the same physician. Therefore, I agree with Ms. Lindenauer's analysis.

I note, too that I concur with the reasoning set forth by Arbitrator Papadakis in Global Surgery Center LLC v. Progressive Casualty Insurance Company, Case # 17-23-1309-2061:

> After a careful review I find for the Respondent. Modifier 59 is inapplicable in this case. Arb. Lester Hill has stated: I find the respondent's argument persuasive that Modifier 59 is not applicable and should not be reported for the surgery. The language utilized under the APG system states that the purposes of the EAPG is to "bundle related services into logical groups for classification, payment and reporting."
> The word "bundle" is prominently in the definition. The stated goal is that the EAPG system is "designed to reflect the resources used in an ambulatory visit. These include nursing and technician time, drugs, supplies, ancillary tests, equipment and treatment time".
> To utilize the multiple incision concept as the basis to justify the use of Modifier 59 for the facility is avoiding the purpose of the EAPG system to group or bundle services to reflect the resources used in the ambulatory visit by the facility.

For all of the foregoing reasons, I find that Respondent has established its fee defense and Applicant is entitled to be reimbursed for its facility fee in the amount of $5,292.93.

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**
	Island Ambulatory Surgery Center LLC	**01/25/24 - 01/25/24**	**$15,889.93**	**Awarded: $5,292.93**
Total			**$15,889.93**	**Awarded: $5,292.93**

B. The insurer shall also compute and pay the applicant interest set forth below. 04/04/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   The date set forth above is the date when the American Arbitration Association received the arbitration request.

   Applicant did not commence arbitration within 30 days after receipt of the denial(s). Therefore, the interest accrual date shall be the said date the American Arbitration Association received the arbitration request. The end date for the period of interest shall

be the date of payment of the claim. Interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. See 11 NYCRR 65-3.9, 65-4.5(s)(3).

C. Attorney's Fees

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

Applicant is entitled to an attorney's fee pursuant to Insurance Law §5106(a). After calculating the sum total of the first-party (No-Fault) benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, subject to the following limitations: In the event the above filing date was prior to Feb. 4, 2015, the attorney's fee is subject to a minimum of $60.00 and a maximum of $850.00, per 11 NYCRR 65-4.6(e). In the event the above filing date was on or after Feb. 4, 2015, the attorney's fee is subject to a maximum of $1,360.00, per 11 NYCRR 65-4.6(d). In the event the above filing date was on or after Feb. 4, 2015 and first-party (No-Fault) benefits are awarded to more than one Applicant herein, the attorney's fee shall be calculated separately for each Applicant, each Applicant's attorney fee being subject to the $1,360.00 maximum.

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

09/08/2024
(Dated)

Rebecca Novak

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:
2ffe8b721b7a800fe69764bb1e2224bf

Electronically Signed

Your name: Rebecca Novak
Signed on: 09/08/2024