

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Global Surgery Center LLC
(Applicant)

- and -

State Farm Mutual Automobile Insurance
Company
(Respondent)

AAA Case No.	17-24-1342-0940
Applicant's File No.	SS-267342
Insurer's Claim File No.	32-56B7-10K
NAIC No.	25178

ARBITRATION AWARD

I, Fred Lutzen, 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: EIP or "Assignor"

1. Hearing(s) held on 08/16/2024
Declared closed by the arbitrator on 08/16/2024

Joseph Padrucco, Esq., from Samandarov & Associates, P.C. participated virtually for the Applicant

Craig Stabenau, Esq., from Sarah C. Varghese & Associates f/k/a James F. Butler & Associates participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$7,117.35**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant amended its claim to \$4,890.73 in its view of fee schedule allowances after the partial payment of \$3,026.24.

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

3. Summary of Issues in Dispute

This male EIP (first initial "Y") was 41-years-old when he was injured as a passenger in an automobile accident on 9/5/2023. He subsequently underwent left knee arthroscopic surgery on 12/21/2023. Applicant seeks reimbursement of the unpaid balance on this claim.

Respondent contends that it paid the full allowed rate per fee schedule.

The issue to be determined is whether the Respondent reimbursed Applicant correctly according to fee schedule allowances.

4. Findings, Conclusions, and Basis Therefor

This case was decided based on prevailing law, the submissions of the parties as contained in the electronic file [MODRIA] maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no live witnesses.

Unless the parties' agreement provides otherwise, an arbitrator need not apply the rules of evidence, is not bound by principles of substantive law, may do justice as he sees it, and may apply his own sense of law and equity to the facts as he finds them to be. Matter of New Century Acupuncture, P.C. v. Country Wide Ins. Co., 48 Misc.3d 1201(A), 18 N.Y.S.3d 580 (Table), 2015 N.Y. Slip Op. 50919(U) at 2, 2015 WL 3821534 (Dist. Ct. Suffolk Co., C. Stephen Hackeling, J., June 18, 2015); see also, *Rules for Arbitration of No-Fault Disputes in the State of New York*; Effective August 16, 2013, [p](1), "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." <https://nysinsurance.adr.org>.

Fee Schedule

Pursuant to *11 NYCRR, Section 65-3.16*, Measurement of no-fault benefits, (a) Medical expenses, (1), "Payment for medical expenses shall be in accordance with fee schedules promulgated under section 5108 of the Insurance Law and contained in Part 68 of this Title (Regulation 83).

The Workers' Compensation fee schedule, which is required by law and incorporated by reference into the Insurance Department Regulations, is of such sufficient authenticity and reliability that it may be given judicial notice, and it need not be submitted to the court. Z.A. Acupuncture, P.C. v. Geico Ins. Co., 33 Misc.3d 127(A), 939 N.Y.S.2d 745 (Table), 2011 N.Y. Slip Op. 51842(U), 2011 WL 4949646 (App. Term 2d, 11th & 13th Dists. Oct. 11, 2011); Lvov Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), 939 N.Y.S.2d 741 (Table), 2011 N.Y. Slip Op. 51721(U), 2011 WL 4424472 (App. Term 2d, 11th & 13th Dists. Sept. 16, 2011).

As such, I take appropriate evidentiary notice of the NY WC Fee Schedule. If the fees can be determined from a straightforward reading of the fee schedule, no coder affidavit or fee audit is required. Absent a straight-forward calculation confirming the correct rate, Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006).

Applicant's original charges, payments, and amendments are as follows:

CPT Code	Billed	Paid / R Coder Opinion	Amended Claim / A Coder Opinion
29880-LT	3026.24	3026.24	0.00
29884-59, LT	1472.45	0.00	1472.45
29876-59, LT	1472.45	0.00	1472.45
29999-59, LT	1472.45	0.00	1472.45
20610-59, LT	2700.00	0.00	473.38
Totals	\$10,143.59	\$3,026.24	\$4,890.73

Applicant's amended amount of \$4,890.73 reflects the partial payment of \$3,026.24 and the reduction of the charge under CPT Code 20610 from \$2,700.00 to \$473.38.

In support of its fee schedule defense, Respondent submitted an affirmation by Erin M. Luke, LPN, CPC, CPMA, dated 5/24/2024. Applicant submitted an affirmation by Aaron J. Perretta, Esq., CPC, in support of its position.

In the first instance, Coder Luke noted that these services were provided in New Jersey. Both coder's provided calculations for New Jersey and New York and agree that the New Jersey rate is higher than the maximum allowed in New York. As such, the New York analyses are the relevant point of contention pursuant to the 33rd Amendment to Insurance Regulation 83.

Both coders noted that the charges are to be calculated according to the EAPG methodology.

Defense

Coder Luke noted the 3M "software is not able to approve the unbundling of CPT® codes but does override the bundling by entering Modifier 59. Medical documentation needs to be reviewed to determine appropriate use of procedure codes and modifiers. [¶] The reported CPT® codes and modifiers were reviewed for accuracy based on the services documented in the medical record in conjunction with CPT® and fee schedule guidelines. A review is necessary to ensure proper reimbursement for the services performed in accordance with the applicable fee schedule. [¶] Modifier 59 was appended to all reported CPT® codes except code 29880." She states, "Use of this

modifier overrides EAPG consolidation logic and NCCI edits applicable to the services in dispute (detailed below in calculation of reimbursement)."

Coder Luke continued [with emphasis from original]:

As explicitly endorsed by the WCB, the NCCI and other embedded edits, "...will be used by the Board to process bills for ambulatory surgery services. These settings are necessary to properly calculate bills for ambulatory surgery services under the NYS worker's compensation system." Therefore, NCCI has direct application in this reimbursement methodology. (See Exhibit D) Regarding modifier 59 NCCI policy manuals clarify: (see Exhibit E)

Modifier 59: Modifier 59 is an important NCCI PTP-associated modifier that is often used incorrectly. With regard to NCCI PTP edits, its primary purpose is to indicate that 2 or more procedures are performed at different anatomic sites or different patient encounters. It shall only be used if no other modifier more appropriately describes the relationships of the 2 or more procedure codes (See Section e for modifiers -X{EPSU}). The "CPT Manual" defines modifier 59 as follows:

Modifier 59: 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 or patient encounter, 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. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Applicant reports CPT® code 29884 for lysis of adhesions. Plain reading of the CPT® Professional definition reveals that this code is designated as a separate procedure. CPT® Professional Guidelines explicitly direct, "*The codes designated as "separate procedure" should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.*" All services in dispute were related to the same surgical arthroscopy of the knee. CPT® code 29884 is not reportable with other surgical arthroscopy procedures performed in the same knee, in accordance with CPT® Professional guidelines. Modifier 59 would only apply if the services described by 29884 were performed in a different area of injury (other knee), by a different physician, or during a different encounter. However, none of the above apply to the services in dispute, thus, modifier 59 is incorrect.

There is an NCCI associated edit between CPT® code 29876 and 29880 for which a modifier may be appropriate if conditions are met. As described below in the calculation of payment, NCCI guidelines explicitly direct that CPT® code 29876 and 29880 may not be reported for the same knee. Since all the services in dispute were provided on the same knee, modifier may not be applied and is removed prior to reimbursement calculation.

There is an NCCI associated edit between CPT® code 20610 and 29880 for which a modifier may be appropriate if conditions are met. As described below in the calculation of payment, NCCI guidelines explicitly direct that injections for postoperative pain injections may not be reported when performed by the surgeon performing the primary surgical procedure. Provider notes performance of an injection of pain medications into the surgical site upon completion of the operation. This injection is not separate and distinct from the surgical service to which it is related. Modifier 59 is incorrect and removed prior to reimbursement calculations.

Provider appends modifier 59 to unlisted CPT® code 29999. There are no identified NCCI edits for this code. Review of the submitted operative report reveals unlisted CPT® code 29999 was reported for arthroscopic coblation services performed on the same area of injury, on the same knee, by the same surgeon and during the same encounter. This is not a distinct service and modifier 59 is not correct and removed prior to reimbursement calculations.

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; *"APG reimbursement methodology takes into consideration the amounts and types of resources used during a visit and is adjusted based on the level of intensity of the services rendered. Reimbursement is made based on the patient's diagnosis, symptoms and acuity, and APGs then systematically package the costs of certain, associated ancillary labs and/or radiology services into the overall reimbursement of the associated significant procedure or medical visit to the facility."* (see Exhibit F)

12CRR-NY 329-2.4 - Diagnostic coding and rate computation; (a) states *"The APG software system shall incorporate methodologies for consolidation, packaging and discounting to be reflected in the final weight to be assigned to the claim."* (see Exhibit A)

Coder Luke then provided the EAPG calculations based on the above rationale. The calculations reflect the EAPG group 0037 (Level 1 Arthroscopy) with EAPG Type 2, the adjusted weight, base payment, add-on payment. She concluded CPT® code 29880 is identified as a significant procedure, as indicated by EAPG Type 2 and is assigned to

EAPG group 0037 (Level I Arthroscopy). Full EAPG payment with capital add-on is applied to CPT® code 29880 in the amount of \$3,026.24."

Coder Luke noted, "The APG Provider Manual explains, *"A significant procedure is a procedure that constitutes the primary reason for the visit and dominates the time and resources expended during the visit."*

Regarding CPT Code 29876, Coder Luke stated, "As above, there is a "Standards of medical / surgical practice" NCCI associated edit identified for CPT® 29876 with code 29880. This edit identifies services (29876) that are component parts of the more comprehensive service (29880). NCCI Policy Guidelines direct, "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 2 of the 3 knee compartments." As previously noted all services in dispute were performed on the ipsilateral (same side) knee, therefore, no payment is issued for CPT® code 29876. (see Exhibit J)."

Regarding CPT Code 29999, Coder Luke stated, "Each CPT® code is assigned an EAPG Type and an EAPG Group. The EAPG type provides a broad classification of the code to identify the type of care being rendered. The 3M APG crosswalk outlines the different EAPG Types a CPT® code may be assigned to (clip from source follows) (see Exhibit G)" and "CPT® code 29999 is assigned to EAPG Type 2 identifying this service as a significant procedure. (clip from source follows)." She stated:

3M Frequently Asked Questions explains that, *"Significant procedure consolidation (consolidation) refers only to significant procedures, 3M EAPGs types 2, 21, 22, 23, 24 or 25."* This means that, if a reported code is assigned any other EAPG Type (1,3,4,5,6,7, or 8) consolidation rules would not apply. (see Exhibit I).

In this case, both CPT® code 29880 and 29999 are assigned to EAPG Type 2 providing that both reported services are considered significant procedures. The APG provider manual continues, *"When a patient has multiple significant procedures, some of the significant procedures may require minimal additional time or resources. Significant procedure consolidation is the consolidation of multiple related significant procedure APGs into a single APG for determining reimbursement."*

To determine if significant procedure consolidation applies to a service, the EAPG group assignment is assessed. As shown in the above clip, CPT® code 29999 is assigned to EAPG 0037 (Level I Arthroscopy). Additionally, concurrently reported CPT® code 29880 is assigned to EAPG 0037.

3M Frequently Asked Questions continues, *"There are two methods of consolidation: Same 3M EAPG and clinical 3M EAPG"*. For same EAPG consolidation, *"When two lines group to the same significant procedure 3M EAPG, one is paid and the second is not paid separately."* (See Exhibit I) Since both primary code 29880 and 29999 are in the same EAPG group and payment is issued for code 29880, no payment is issued for code 29999.

Regarding CPT Code 20610, Coder Luke stated:

CPT® code 20610 was reported by Applicant for an injection of pain medication, by the surgeon, into the surgical site, at the completion of the surgery. (see Exhibit H) NCCI guidelines explicitly direct that such service is not reportable by the surgeon stating, "*Under the NCCI program, postoperative pain management is not separately reportable when it is provided by the physician performing an operative procedure.*" (see Exhibit J) Thus, no payment is issued for code 20610.

Rebuttal Case

In rebuttal, Coder Perretta stated, "In this matter, Respondent annexes a fee review affidavit by penned by Erin Luke, CPC, in which unsubstantiated claims unsupported by the record are made in regards to the application of the applicable EAPG Framework to the bill at issue."

Coder Perretta outlined the 3M framework as did Coder Luke. Coder Perretta noted that the "main procedure code" of 29880 was calculated correctly.

Coder Perretta stated [with all emphasis from original], "Remaining surgical Codes 29884, 29876 and 29999 are subsequently reimbursed at 50% of its EAPG value, as they are not the main procedure, share an identical base value, and this Code would have otherwise been bundled into Code 29880 if not for Applicant appending Modifier 59 to them (to be explained *infra*). And 3M dictates Code 20610 is to be reimbursed at 100% of its EAPG value, as it is assigned a lesser-valued EAPG Procedure Code of 49, to be discussed *infra*."

Coder Perretta urges that Applicant correctly applied Modifier 59 to the remaining codes and that 50% is to be reimbursed per the APG Provider Manual, stating, "As applied to the instant matter, although Codes 29884, 29876, 29999 and 20610 are unbundled from one another and main procedure Code 29880, since Modifier 59 was affixed to Codes 29884, 29876, 29999 and 20610."

Coder Perretta stated:

[Coder] Luke refuses to input Modifier 59 alongside codes 29884, 29876, 29999 and 20610 into 3M when calculating the rates of reimbursement. This omission is made evident by the fact that Luke explicitly states for each of the aforementioned codes, "However, none of the above apply to the services in dispute, thus, modifier 59 is incorrect [...] Since all the services in dispute were provided on the same knee, modifier may not be applied and is removed prior to reimbursement calculation [...] Modifier 59 is incorrect and removed prior to reimbursement calculations [...] This is not a distinct service and modifier 59 is not correct and removed prior to reimbursement calculations." See Luke, Fee Audit, pp. 6-7.

[] This is incorrect.

[] [Coder] Luke's incorrect retelling of the bill is exemplified by the fact that Luke's 3M reproduction indicates Codes 29884, 29876, 29999 and 20610 are assigned an adjusted weight as "0.0000," while Code 29880 is assigned a weight of 9.9509, which is simply not true in this particular case. Had Luke inputted Modifier 59 alongside the codes as billed into 3M, 3M would have assigned Code 29880 an adjusted weight of 9.9509, and Codes 29884, 29876, 29999 and 20610 adjusted weights of 4.9755, 4.9755, 4.9755, and 1.5996, respectively.

[] Please see the red boxes affixed by Applicant to its 3M printout in EXHIBIT C to highlight the differences between these two 3M printouts. Conversely, Applicant's 3M printout - where Modifier 59 was inputted - does permit reimbursement for codes 29884, 29876, 29999 and 20610. *Id.*

[] Luke is creating a completely new bill by removing modifiers from the codes. In order for Luke to truly strengthen and eventually prove her position, she needs to input all of the codes and modifiers as billed, and then explain why they are not entitled to payment. Luke rewriting the patient's medical journey at the expense of the medical providers performing these benefits is simply wrong.

Furthermore, it is simply not true that 3M will always override the bundling, an NCCI Edit (to be discussed at length *infra*), or guarantee a code payment when Modifier 59 is appended; Modifier 59 is NOT an absolute. Because, there absolutely do exist codes that simply may NEVER be coded alongside others. However, in THIS instance, Modifier 59 does afford Applicant payment to the codes to which it is appended.

[]

[] For instance, 3M will NEVER reimburse codes 29874 and 29877 when billed with other knee surgery codes. Annexed hereto as part of EXHIBIT G is a 3M printout in which Codes 29881, 29877 and 29874 are entered into the 3M software, where Modifier 59 is appended to both Codes 29877 and 29874. Yet, Codes 29877 and 29874 are NOT reimbursed. This is true for many other Codes as well.

[] Thus, Applicant submits that - at the very least - Luke's affirmation is flawed and/or incomplete since she refused to input the Codes as reported in 3M. And Applicant will explain in great detail *supra* why removing Modifier 59 from the bill is improper.

[]

[] Because Luke fails to "conclusively establish" in a "coherent manner" how Modifier 59 would affect the reimbursement of Codes 29884, 29876, 29999 and 20610, Luke's fee affidavit fails to shift the burden upon Applicant in these regards.

Coder Perretta disagreed with Coder Luke's reliance on NCCI edits and contends that Modifier 59 was properly used.

Coder Perretta continued:

Despite what Luke argues or how she words her arguments, it is clear the AMA's Modifier 59 description simply states it may be properly appended in instances where services are performed upon "different sites or organ systems, "and may be properly appended in instances where there exist "separate incisions/excisions" and "different procedures or surgery."

[] Applicant's bill and operative report stand for the position that its use of Modifier 59 permits Codes 29884, 29876, 29999 and 20610 to be properly coded with Code 29880, per the AMA's descriptor of same. Per the operative report annexed hereto as **EXHIBIT A** for this arbitrator's convenience, it is clear **two separate incisions** were performed upon the patient at the lateral portal incision site ("A stab incision was made in the left knee lateral portal site."), and medial incision site ("A spinal needle was placed through the medial portal site. The needle was visualized and a small stab incision was made.").

Furthermore, **five different procedures** were performed on different parts of the patient's left knee, as denoted under the "Operative Procedure" section of the operative report.

[]

[] Because Luke fails to "conclusively establish" in a "coherent manner" as to how Modifier 59 affects the reimbursement rates of Codes 29821, 29823 and 29825 per 3M, Luke's fee affidavit fails to shift the burden upon Applicant in this regard.

Coder Perretta asserts that Coder Luke "fails to prove her use of the NCCI Policy Manual or NCCI PTP Edits may be properly utilized with the EAPG framework."

Coder Perretta provided further support for his opinion that the NCCI edits were improperly relied upon and I've reviewed the entire report of both coders.

Analysis

I find that Respondent's coder has provided a comprehensive and persuasive analysis supported by references. The primary issue is whether Modifier 59 was properly applied. In urging that this was proper, Coder Perretta did not address the primary point of contention. Modifier 59 is to be used under various circumstances for services "not ordinarily encountered or performed on the same day by the same individual."

The procedures were all performed on the same left knee, and included synovectomy, meniscectomy, arthrocentesis, lysis of adhesions, and coblation arthroplasty/debridement.

Coder Perretta did not explain why these procedures would not be ordinarily encountered or performed on the same day by the same individual. This factfinder cannot imagine, without expert assistance, why or how a person would have a meniscectomy performed and the surgeon delay, for another day, the debridement or synovectomy on the same left knee. Logic dictates that these would **always** be

performed on the same day in the same operative session absent an expert opinion to explain otherwise.

After comparing the two coding analyses, I am persuaded by Coder Luke. The rationale is more logical and factually-based.

Coder Luke's opinion and analysis meets Respondent's burden of proof. Her affidavit constitutes "competent evidentiary proof to support its fee schedule defenses." *See, Robert Physical Therapy PC., supra.* Applicant's coding analysis by Coder Perretta is unpersuasive as there was no explanation for why the multiple services would "not ordinarily encountered or performed on the same day by the same individual." Applicant has failed to rebut the opinion by Coder Luke.

Conclusion

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 Respondent.

The partial denial is sustained as full payment was issued.

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 Onondaga

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

09/11/2024
(Dated)

Fred Lutzen

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:
512dc1eb2462a4977bdbb3a97987c688

Electronically Signed

Your name: Fred Lutzen
Signed on: 09/11/2024