American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Triborough ASC (Applicant)	AAA Case No.	17-23-1329-3097
	Applicant's File No.	00125272
- and -	Insurer's Claim File No.	23-2976557
	NAIC No.	24260
Progressive Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Donald MacKenzie, 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

1. Hearing(s) held on 08/30/2024
   Declared closed by the arbitrator on 08/30/2024

   Sasha Hochman from Drachman Katz, LLP participated virtually for the Applicant

   Liz Peabody from Progressive Casualty Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$2,652.04**, 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 EIP, WKH, a 66 year old male was involved in a motor vehicle accident on 4/3/23. At issue in this case is the amended fee of $2,605.78 for surgery performed on 8/7/23. Respondent based payment on the fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

   This case was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral

arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

Insurance Law § 5102(a)(1) defines "basic economic loss" as including "all necessary expenses incurred for…professional health services" subject to the limitations of Insurance Law § 5108. Insurance Law § 5108 limits the amounts to be charged by providers of health services, and states that charges for services specified in Insurance Law § 5102(a)(1) "shall not exceed the charges permissible under the schedules prepared and established by the chairman for the workers' compensation board…except where the insurer…determines that unusual procedures or unique circumstances justify the excess charge." 11 NYCRR § 65-3.16(a) provides that "[p]ayment 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)." 11 NYCRR § 68.1 provides that the "existing fee schedules prepared and established by the chairman of the Workers' Compensation Board…are hereby adopted by the Superintendent of Insurance with appropriate modifications so as to adapt such schedules for use pursuant to section 5108 of the Insurance Law."

It is well settled that the health care provider establishes it prima facie entitlement to no-fault benefits under article 51 of the Insurance Law by offering proof that it submitted documentation setting forth the particulars of the claim to the insurer and that payment of same is overdue. See Mary Immaculate Hospital v. Allstate Insurance Company, 5 AD3d 742(2nd Dept. 2004); Amaze Medical Supply v. Eagle Insurance, 2 Misc 3d 128A, 784 NYS2d 918, 2003 N.Y. Slip Op 5170IU (App. Term, 2d & 11th Jud. Dist].

Respondent submit the coder affidavit of Sarah Lindenauer. Applicant submitted a claim for medical services allegedly performed on August 7, 2023. The claim was for a surgical procedure and used CPT Codes 22899 and 22526-59- the provider billed a total of $7,944.97 for this bill. Effective October 1, 2015, the New Enhanced Ambulatory Payment Groups ("EAPG") Fee Schedule applied to Ambulatory Surgical Centers and Hospitals. Pursuant to 12 NYCRR 329-2.1 "Payment for ambulatory surgery services shall be made according to the ambulatory patient groups (APG) methodology, governing reimbursement for licenses freestanding ambulatory surgical centers and hospital-based ambulatory surgery services as set forth herein and subject to Workers' Compensation Board specific adjustments." Workers' Compensation Board Memo Subject Number 046-784 discusses the change and Implementation Guide discussing the application of the APG methodology. Per the Workers Compensation Enhanced Ambulatory Patient Group (EAPG) …FAQ #3 states, "calculations are performed either through the use of the 3M Grouper software, or manually." Whether manual or through the use of the 3M Grouper Software, what needs to be taken into consideration is that the 3M software is just that, a software program it is only as reliable as the information that it is being supplied with. Respondent has elected to manually calculate the allowable fees for the services provided. Review of the records submitted in support of the claim demonstrate that after adjustments the fee schedule allowable is $5,292.93. The calculation for the maximum amount allowed under the EAPG Fee Schedule is the "APG Code Weight" multiplied by the "New York Workers Compensation Base Rate"

which equals the subtotal. The Capital Add-On then gets added where appropriate to arrive at the total payment for the primary APG group. APG groups other than the primary APG group do not receive a Capital Add-On.

The APG Code Weight is based on the APG Code, and the CPT Code/procedure performed (as followed by Medicaid and the New York Department of Health). Based on the Implementation Guide Appendix A; The New York Worker's Compensation Base Rate is derived from 150% of Medicaid's hospital base rate. The NY WCB rate, as well as the Capital Add-On has two regions: upstate and downstate. For the upstate region, the NY WCB rate is $228.62 and for downstate is $295.94. For the upstate region, the Capital Add-On is $109.90 for Ambulatory Surgery Centers and $108.48 for Hospitals. For the downstate region the Capital Add-On is $81.37 for Ambulatory Surgery Centers and $115.70 for Hospitals. The 3M Presentation, pg. 3, "NY Workers Compensation. vs. NY Medicaid," indicates the NY Workers' compensation ambulatory surgery payment logic is "consistent with logic implemented by NY Medicaid (DoH)." The 3M Presentation on page 6 states that the NCCI & MUE Edits only apply for Medicaid use. Since NYS Workers Compensation EAPG logic is consistent with NY Medicaid the NCCI and MUE edits would apply. Attached at Exhibits "4". According to the NYS DOH website the Ambulatory Patient Groups (APGs) Medicaid Fee For-Service Provider Manual Policy and Billing Guidelines revised 12/29/21, page 18, 3.8 National Correct Coding Initiative (NCCI) Edits, "NCCI edits were developed by CMS to support national practice, coding and billing standards. NCCI edits are utilized by Medicare and most private insurers and reflect nationally accepted correct coding standards. NCCI edits are used to prevent inappropriate reimbursement of services that should not be reported together for the same date of service by the same provider; services that are integral to another comprehensive service separately coded; and services that should never be performed with another service or procedure. The provider may need to append 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".

Based on the 3M EAPG Presentation, the use of modifier -59 "Turns off consolidation - allows separate payment. Page 18 of the NY presentation is titled "Modifiers used in EAPGs' general discussion." Page 18 of the presentation does not talk about the proper use of modifiers; it is a general description of what the modifier will do. The presentation indicates that if modifier 59 is used it will turn off consolidation and allow payment. Attached at Exhibits "5"16. The "Health Care Information - Workers' Compensation Enhanced Ambulatory Patient Group (EAPG)" FAQs - #22, referred to specifically indicate the Hospital outpatient NCCI Edits/Manuals and Medical Unlikely Edits are to be used; these edits are found on the CMS Website. This same CMS website is clear that Hospital Edits are for just that - Hospitals - and that Ambulatory Surgery Centers are to use the Practitioner Edits. This site also outlines the proper use of the NCCI Manuals; these manuals/guidelines are the same whether the provider is a hospital or an ambulatory surgery center. NCCI indicates regarding modifier -59, "Modifier 59 is an important NCCI-associated modifier that is often used incorrectly. For the NCCI its primary purpose is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters." This is not the case with the billing in dispute. From an NCCI perspective, the definition of different anatomic sites includes

different organs, different anatomic regions, or different lesions in the same organ. It does not include treatment of contiguous structures in the same organ or anatomic region. There is no NCCI edit between codes 22526 or 22899- they may be billed together. This does not mean, however, the application of modifier -59 is automatically appropriate. The criteria based on the guidelines outlined (separate session/different anatomic site) still needs to be met; if it is not, the modifier is improper for facility billing. 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 code 22526. The operative report indicates all procedures were performed at the same level(s), therefore modifier -59 would not be appropriate; since the procedures billed are listed in APG 28, payment would be consolidated. Review of the EAPG Schedules in the 3M APG Crosswalk database assigns CPT Codes 22899 & 22526 to APG 28, The application of the predetermined weight, discounts, rate, and capital add on result in CPT Code 22899 being compensated at 100% of the EAPG amount of $5,292.93. Attached were copies of the relevant APG Groups from the 3M APG Crosswalk database, Weight Chart and Manual Calculation Sheet.

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. Progressive previously issued payment in the amount of $5,292.93; therefore, it was her position no further payment is due.

Applicant submits and IHC report from an unrelated case in support of code 22526. The report supported payment of code 62287 at 100% and 22526 at 50%. The question presented was whether CPT code 62287 is exclusive from CPT code 22526. CPT code 62287 procedure percutaneous decompression, also known as "Stryker Disc Dekompressor Discectomy: is a procedure when a doctor inserts a needle called "canulla" through patient's number skin, guided by fluoroscope, into the bulging disc. A special probe with spinning tip is inserted through cannula to remove small part of the center of the disc that relieves pressure inside of the disc reducing the bulge and relieving the pressure. No thermal affect is involved this is a different procedure covered and recognized by CMS. CPT 62287 being included in CPT 22526 this reference could mean if the procedure involved thermal intradiscal procedure or misinterpreted edits of that year. These two minimally invasive surgeries are not mutually inclusive or exclusive just separate different procedures.

I credit the report of the respondents coder and note the surgical report had the procedure performed at level C4-C5. The issues raised were not addressed or rebutted by the IHC report which was not case specific. Application denied.

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 Nassau

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

09/24/2024
(Dated)

Donald MacKenzie

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:
b2ad122559e5f4625a6e3b48cebdb87a

Electronically Signed

Your name: Donald MacKenzie
Signed on: 09/24/2024