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.	17-24-1341-6085
	Applicant's File No.	00130318
- and -	Insurer's Claim File No.	GENO-004765
	NAIC No.	
Accident Fund Insurance Company of America (Respondent)		

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 09/11/2024
   Declared closed by the arbitrator on 09/11/2024

   Justin Rosenbaum, Esq., from Drachman Katz, LLP participated virtually for the Applicant

   Kimberly Glock, Esq., from Law Office of Jason Tenenbaum, PC participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$10,593.29**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant amended its claim to $7,898.75 in its view of fee schedule allowances.

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

3. Summary of Issues in Dispute

   This female EIP (first initial "C") was 26-years-old when she was injured as a passenger in an automobile accident on 7/2/2023. She subsequently underwent percutaneous discectomy and annuloplasty on 10/20/2023. Applicant seeks reimbursement for the facility [ASC] services provided in connection with these procedures.

Respondent contends the permissible rate of reimbursement is $5,296.65.

The only issue to be determined is whether the charges are within 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.

Introduction

The reason the only issue concerns the fee schedule is that Respondent received Applicant's bill on 10/31/2023 and denied the claim on 12/22/2023 with no evidence of properly delaying the bill by seeking additional verification. Therefore, the denial was late per the Regulations and the medical necessity defense was waived. Pursuant to New York law, the insurer is precluded from asserting a defense of lack of medical necessity where a denial was not issued within 30 days after receipt of the claim. Lenox Hill Hospital v. Liberty Mutual Ins. Co., N.Y.L.J., Aug. 15, 2003, p. 21, col. 3 (Dist. Ct. Nassau Co., Kenneth Gartner, J.).

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).

In this case, Respondent submitted a coding analysis by Dardan Bunjaku, Certified Coder, dated 9/11/2024, and Applicant submitted a copy of an IHC Report prepared by Julia Nabiullina, Certified Coder, dated 7/7/2020, which addresses the same CPT Codes at issue here.

Both sides agree that CPT Code 62287 is reimbursable at $5,292.96. The disagreement involves CPT Code 22526. Applicant contends it is reimbursable at 50% or $2,605.79 and Respondent contends that code 22526 is included in code 62287.

Respondent's Argument

Coder Bunjaku stated, in relevant part:

> [1] **CPT code 22526** pertains to percutaneous intradiscal electrothermal annuloplasty, which may be performed unilaterally or bilaterally, including the use of fluoroscopic guidance, applicable to a single level.
>
> [2] The provider also billed for nucleoplasty under **CPT code 62287**. This code describes a plasma disc decompression procedure-percutaneous decompression of the nucleus pulposus of an intervertebral disc, utilizing a needle-based technique to remove disc material under fluoroscopic imaging or other forms of indirect visualization, accompanied by discography and/or epidural injections at the treated level(s), whether at a single or multiple lumbar levels.
>
> [3] Additionally, **CPT code 22899** was billed, but the specific procedure performed under this unlisted code is not detailed in the medical records, and it appears that all performed procedures are already accounted for in the existing CPT codes.
>
> [4] All three codes fall under APG 28, denoted as LEVEL I SPINE PROCEDURES. The classification of **CPT codes 22526, 62287, and 22899 under APG 28 as Level I Spine Procedures** is grounded in the procedural complexity, targeted anatomical site, and the nature of the interventions these codes represent. CPT code 22526, which describes percutaneous intradiscal electrothermal annuloplasty, involves a minimally invasive technique that uses heat to modify the structure of the vertebral disc's annulus fibrosus, aiming to alleviate back pain. This procedure requires precision and fluoroscopic guidance for accurate placement, underscoring its sophistication and specificity to spinal treatment. Although CPT

code 22899 is included, the procedure performed is not specified in the medical records, and it should also be classified under Level I Spine Procedures because the whole process does not qualify it as a Level II Spine Procedure. (**Exhibit C**-APG APG Based Weights)

[5] The procedures described, including those under CPT codes 22526 and 62287, involve minimally invasive techniques and are aimed at decompression and annuloplasty, which do not entail the higher complexity, extensive surgical approach, or prolonged operative times characteristic of Level II Spine Procedures. Level II Spine Procedures generally include more invasive surgeries such as spinal fusions, complex vertebral reconstructions, or multi-level decompressions which require significant surgical time and resource utilization, neither of which are applicable to the described interventions in this case.

[6] CPT code 62287 describes plasma disc decompression, also known as nucleoplasty. This procedure involves a percutaneous, needle-based technique to decompress and remove material from the nucleus pulposus of an intervertebral disc under fluoroscopic imaging. It often includes discography and/or epidural injections at the treated levels. This method targets disc-related pathologies and is indicative of an advanced level of intervention within the lumbar region, further justifying its placement within the Level I Spine Procedures category.

[7] In accordance with the New York Health Department's APG Manual, which promotes the consolidation of related procedures to streamline billing and ensure equitable reimbursement, CPT 22526, denoting additional levels of annuloplasty, is inherently consolidated under CPT 62287. Similarly, CPT 22527, which also pertains to additional levels of annuloplasty, is consolidated in the same manner. This consolidation negates separate reimbursement for CPT 22526 as they do not add significant time or complexity beyond the primary procedure, thereby aligning with the principles of efficiency and clinical judgment the APG system is designed to uphold. The inclusion of CPT code 22899 in the billing is also problematic, as the medical records do not specify the unique procedure performed under this code. Since all procedures performed are already accounted for under the existing CPT codes, and no additional complexity or time requirement is documented, CPT 22899 should also be considered under the same principles of consolidation and not separately reimbursed.

[8] Consolidation Rule: According to the APG policy, when multiple procedures fall under the same EAPG classification, they are subject to consolidation. This policy is predicated on the understanding that related procedures performed during the same operative session generally require less overall resource usage than if they were performed independently. Thus, the policy aims to prevent unnecessary multiple charge accruals for procedures that are technically or clinically related. (See Exhibit A- APG Manual Provider on page 12 & Exhibit B-Ambulatory Patients Groups Implementation on page 9).

As per Ambulatory Patients Groups Implementation from NYS DOH:

Consolidation (or Bundling)

- The inclusion of payment for a related procedure into the payment for a more significant procedure provided during the same visit.
- CPT codes that group the same APG are consolidated

> [9] Application of Modifier 59 as per APG Policy and Billing Guidance: The use of Modifier 59 for CPT code 22526 is not justified, as the procedures under 22526 and 62287 target the lumbar spine and use fluoroscopic guidance, making them closely related rather than distinct. Modifier 59 is intended to identify procedures that are clearly separate in terms of anatomical sites, surgical goals, or encounters. Here, both 22526, involving percutaneous intradiscal electrothermal annuloplasty, and 62287, for plasma disc decompression, are performed as part of a unified treatment strategy. Given their overlapping technical and anatomical characteristics, the application of Modifier 59 would be inappropriate. The intent of Modifier 59 is to denote procedures that are distinct due to differences in anatomical sites, surgical intent, or patient encounters. In this scenario, both CPT 22526 and 62287 involve the lumbar spine and the use of fluoroscopic guidance to perform annuloplasty and decompression, making them part of the same procedural continuum rather than separate, distinct procedures. Additionally, the inclusion of CPT code 22899 lacks justification, as the medical records do not specify the unique procedure performed under this code. The procedures performed are already accounted for under the existing CPT codes, further reinforcing that Modifier 59 is not appropriate in this context.
>
> Applying Modifier 59 implies that these interventions are independent of each other, which is misleading given their overlapping therapeutic objectives and techniques. The APG system emphasizes that treatments targeting the same area, especially when similar in nature, should be considered components of a holistic therapeutic approach rather than distinct procedures eligible for separate reimbursement. This perspective aligns with the APG's consolidation principle, which discourages the segmented billing of related procedures that are performed together.

Coder Bunjaku summarizes the position as to code 22526, stating, "Consolidated as part of Level I Spine Procedures because it is a minimally invasive procedure targeting the lumbar spine, utilizing fluoroscopic guidance, and falling under the same procedural category as related spine interventions, thus reducing overall resource usage when performed with similar procedures. [and] Consolidated as part of Level I Spine Procedures because the medical records do not specify the unique procedure performed, and all documented procedures are already accounted for in the existing CPT codes, indicating that it does not add significant time or complexity beyond the primary procedures."

Coder Bunjaku added, "According to AMA CPT Assistant, 62287 and 22526 cannot be reported together, even with modifier 59, however since they both fall under the same APG Classification from a fee schedule perspective for APG bills, it does not make a difference."

Applicant's Argument

In the IHC Report related to AAA Case No. 17-19-1149-3725, Coder Julia Nabiullina concluded, in relevant part:

> Conclusion

A. It appears that Carolyn Mallory, CPC (GEICO) has been using outdated guideline that does not support changes in Healthcare field, including switch to the ICD-10. Based on the items listed above, I agree with Alpa Prajapati, CPC (ASC) that since Date of Service was in July 2019 the appropriate guideline has to be used.

B. According to the updated guideline found in attached "Frequently Asked Questions: Implementing the 3M Enhanced Ambulatory Patient Grouping System", page 7,

â Significant procedure consolidation (consolidation) refers only to significant procedures, 3M EAPGs types **2, 21, 22, 23, 24** or **25** (as of 2017).

â **EAPG type in discussion is 28, which is not applicable to the Significant procedure consolidation rule above**. For more details, if needed, one can reference to the presentation from 3M as of Feb 2017 (attached) "Introduction to 3M EAPGs {3M ™ Enhanced Ambulatory Patient Groupings)"

2. **CPT code 62287 is exclusive from CPT code 22526**

Problem Statement:parties disagree whether 2 aforementioned procedure codes are mutually inclusive or exclusive. Items for Consideration:

(a) Although Intradiscal Electrothermal Annuloplasty (IDET) was approved by the FDA in 1998, IDET was regarded by many carriers as experimental. Up to recently, no CPT code existed to describe the procedure, so different variations were used with different payers to get reimbursed, such as 22899 (unlisted procedure, spine); 64999 (unlisted procedure, nervous system) OR CPT in question 62287 (aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar [e.g., manual or automated percutaneous diskectomy, percutaneous laser diskectomy]). Even if the means and processes were different for those procedures, 62287 was accepted and payable for IDET.

(b) However, in 2007 new specific codes have been created for percutaneous thermal intradiscal procedures (TIPs), involving the insertion of a catheter(s)/probe(s) in the spinal disc under fluoroscopic guidance for the purpose of producing or applying heat and/or disruption within the disc to relieve low back pain (CPT 22526 as disputed). Moreover, for lack of evidence on efficiency, Medicare declared IDET procedures as non-covered services and perform only with Advanced Beneficiary Notice (ABN) only, demonstrating the out-of-pocket cost for the patient. Understanding, that many providers have been using CPT code 62287 (decompression procedure) for IDET as indicated above, in January 2009 CMS posted a new National Coverage Determination (NCO) advising that CPT code 22526 should be denied as on covered along with CPT 62287 for **thermal intradiscal procedures** (attached "MLN Matters Number: MM6291"). In the document, page 2, CMS outlined clearly:

* "Percutaneous disc decompression or nucleoplasty procedures that do not utilize a radiofrequency energy source or electrothermal energy (such as the disc decompresser procedure or laser procedure) are not within this NCD's scope" and advised payers to review notes for the word "thermal" or "radiofrequency", "electrothermal" in the notes to rule out possible case of non-covered service.

(c) While Medicare does not pay for IDET, it appears that Medicaid and WC still list that procedure for payment.

(d) CPT code 62287 procedure- percutaneous disc decompression, also known as "Stryker Disc Dekompressor Discectomy" is a procedure when a Doctor inserts a needle called "cannula" through patient's numbed skin, guided by fluoroscope, into the buldging 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.

Conclusion:It appears that Carolyn Mallory, CPC (GEICO) has been utilizing a coding assistant from some publishing company that indicated CPT 62287 being included in CPT 22526. To our understanding, this reference could mean if the procedure involved thermal intradiscal procedure or misinterpreted edits of that year. As indicated above, these two minimally invasive surgeries **are not mutually inclusive or exclusive**- just separate different procedures. If covered by the payor, both should be reimbursable. However, discounted 50% price will be applied since the ASC is working with the same incision and tools.

Problem Statement:parties disagree on modifier usage and correct using of NCCI Edits.
Conclusion:Based on the previous conclusion that 2 procedures cannot be mutually inclusive or exclusive, and upon investigating NCCI Edits, our firm confirmed that there is no indication in the NCCI policy to include/exclude/use modifier with those procedures. Modifier usage only carries additional message to the insurance company and does not impact reimbursement unless indicated so in NCCI edits. Intention-wise, by using Modifier 59 (defined as "Distinct Procedural Service"), our firm understands that ASC was trying to deliver the message to the Payor that Decompression was distinct from the Thermal Intradiscal Procedure. Since it does not affect coverage or payment information in this particular case, instance is considered to be immaterial for further consideration.

While it is typically not imperative that a coder report or IHC Report be prepared specific to the case at hand, the disputed coder report by Carolyn Mallory is not available for my review and so it is not clear which references Coder Nabiullina meant when stating that Coder Mallory relied on "some publishing company that indicated CPT 62287 being included in CPT 22526." However, this was not the only rationale provided by Coder Bunjaku.

Coder Bunjaku also cited the Ambulatory Patients Groups Implementation from NYS DOH, and the New York Health Department's APG Manual, and noted that "CPT codes 22526, 62287, and 22899 under APG 28 as Level I Spine Procedures" and not to be unbundled but consolidated as the "APG system emphasizes that treatments targeting the same area, especially when similar in nature, should be considered components of a holistic therapeutic approach rather than distinct procedures eligible for separate reimbursement. This perspective aligns with the APG's consolidation principle, which discourages the segmented billing of related procedures that are performed together."

It is also noteworthy that Coder Nabiullina stated/quoted from MLN Matters that "Percutaneous disc decompression or nucleoplasty procedures that do not utilize a radiofrequency energy source or electrothermal energy (such as the disc decompresser procedure or laser procedure) are not within this NCD's scope" and advised payers to review notes for the word "thermal" or "radiofrequency", "electrothermal" in the notes to rule out possible case of non-covered service."

In this case, the annuloplasty did use radiofrequency and, therefore, was within the NCD's scope.

In this case, the annuloplasty was also performed at the same L5-S1 level as the percutaneous discectomy.

Modifier 59 provides, "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 and extensive injuries) not ordinarily encountered or performed on the same day by the same individual."

Coder Bunjaku asserted that these codes are included in the total facility payment and do not warrant separate reimbursement and noted, further, that under the NCCI General Ground Rules and Guidelines, the use of modifier 59 is not appropriate in this case because both CPT code 66287 and code 22526 are listed in APG group 28.

For this specific case, the IHC Report is insufficient and does not rebut the persuasive, factually-based, and well supported rationale by Coder Bunjaku.

Coder Bunjaku's opinion and analysis meets Respondent's burden of proof. The affidavit constitutes "competent evidentiary proof to support its fee schedule defenses." *See*, Robert Physical Therapy PC., *supra*. Applicant's coding evidence 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 Bunjaku.

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 Applicant, in part, and in favor of Respondent as to CPT Code 22526.

Applicant is awarded $5,292.96.

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	Amount Amended	Status
	Island Ambulatory Surgery Center LLC	**10/20/23 - 10/20/23**	**$10,593.29**	**$7,898.75**	**Awarded: $5,292.96**
Total			**$10,593.29**		**Awarded: $5,292.96**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/09/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. *See generally*, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30-day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." *See*, 11 NYCRR 65-3.9(c); and OGC Op. No. 10-09-05 (interest accrues from date Applicant "*actually requests arbitration*" or commences a lawsuit). The Superintendent and the New York Court of Appeals have interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009). Interest begins the first business day following a weekend arbitration request or due date.

C. Attorney's Fees

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

Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or the court, subject to a maximum fee of $1360." *Id*.

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 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.

10/04/2024
(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:
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Electronically Signed

Your name: Fred Lutzen
Signed on: 10/04/2024