

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Surgicore Of Jersey City, LLC
(Applicant)

- and -

Allstate Indemnity Company
(Respondent)

AAA Case No. 17-24-1354-6820

Applicant's File No. SS-269984

Insurer's Claim File No. 0726592990
JCO

NAIC No. 19240

ARBITRATION AWARD

I, Tasha Dandridge-Richburg, 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 12/17/2024
Declared closed by the arbitrator on 01/19/2025

Greg Itengen, Esq from Samandarov & Associates, P.C. participated virtually for the Applicant

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

2. The amount claimed in the Arbitration Request, **\$12,889.31**, 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 36 year-old male EIP was the driver of a motor vehicle that was involved in an accident on August 19, 2023. At issue in this case is \$12,889.31 for the facility fee for a left shoulder surgery and injections with ultrasound guidance performed on date of service January 31, 2024. The treatment/services were timely denied based upon a peer review report prepared by Regina Hillsman, MD dated March 8, 2024. Additionally, Respondent contends that the fees charged exceeded those allowable pursuant to the Workers' Compensation Fee Schedule.

4. Findings, Conclusions, and Basis Therefor

Pursuant to 11 NYCRR §65-4.5(o)(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. 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. This Award is based upon a review of all of the documents contained within the ADR Center electronic case file as of the date of the Award, as well as upon any oral arguments by or on behalf of the parties and any testimony given during the hearing.

DR. HILLSMAN'S PEER REVIEW

Dr. Hillsman prepared a peer review report dated March 8, 2024 of the appropriateness of the left shoulder surgery and related services performed on date of service January 31, 2024. Following her review of medical records, Dr. Hillsman concluded that the treatment/services were not medically necessary. Dr. Hillsman's report indicates:

In this case, the claimant was involved in a motor vehicle accident on 8/19/2023 and had left shoulder pain. Left shoulder arthroscopy was performed on 1/31/2024. The standard of care states that if the claimant demonstrated persistent pain, which would be characterized as non-responsive to different types of therapy, including painkillers and intensive physical therapy, an operative procedure might be considered several months later. As per the available medical records, the claimant received physical therapy from 8/28/2023 to 1/18/2024 in a total of 42 sessions for the left shoulder. The conservative treatment received by the claimant was adequate to resolve the complaints. As per my IME report dated 1/11/2024, examination of the left shoulder revealed normal findings. The diagnosis was left shoulder strain, resolved. There was no medical necessity for further orthopedic treatment. There was no medical necessity for physical therapy, diagnostic testing, durable medical equipment, household help, or ambulatory services. There was no medical necessity for the use of prescription medications. There was no evidence of recent diagnostic studies performed after the IME evaluation that would reveal persistent complaints. This concluded that the claimant's left shoulder condition was resolved and there was no necessity for further treatment. It was not clear why left shoulder surgery was recommended when the claimant's condition was resolved. Hence, based on the available medical records, left shoulder arthroscopy performed was not medically necessary.

Analysis

Once an applicant has established a prima facie case of entitlement to No-Fault benefits, the burden then shifts to the insurer to prove that the disputed services were not medically necessary. To meet this burden, the insurer's denial(s) of the applicant's claim(s) must be based on a peer review, IME report, or other competent medical evidence that sets forth a clear factual basis and a medical rationale for the denial(s). *Amaze Medical Supply, Inc. v. Eagle Ins. Co.*, 2 Misc. 3d 128A (App. Term, 2nd Dept., 2003); *Tahir v. Progressive Cas. Ins. Co.*, 12 Misc. 3d 657 (N.Y.C. Civ. Ct., N.Y. Co., 2006); *Healing Hands Chiropractic, P.C. v. Nationwide Assurance Co.*, 5 Misc. 3d 975 (N.Y.C. Civ. Ct., N.Y. Co., 2004); *Millennium Radiology, P.C. v. New York Cent. Mut.*, 23 Misc. 3d 1121(A) (N.Y.C. Civ. Ct., Richmond Co., 2009); *Beal-Medea Prods., Inc. v GEICO Gen. Ins. Co.*, 27 Misc. 3d 1218(A) (N.Y.C. Civ. Ct., Kings Co., 2010); *All Boro Psychological Servs., P.C. v GEICO Gen. Ins. Co.*, 34 Misc. 3d 1219(A) (N.Y.C. Civ. Ct., Kings Co., 2012).

I find that Dr. Hillsman's peer review report fails to set forth a clear factual basis and a medical rationale for Respondent's denial of Applicant's claim for the treatment/services in dispute herein and as such, I find that Respondent has failed to establish a lack of medical necessity for same. Dr. Hillsman essentially argues that the EIP underwent physical therapy, which was sufficient to relieve his pain and that based upon her independent examination, the EIP's left shoulder condition was resolved. Dr. Hillsman's analysis ignores the EIP's left shoulder MRI findings, which suggested there was a full-thickness rotator cuff tear. Said tear was then confirmed by the surgical procedure. In light of the findings of the MRI and the surgical procedure, I am unconvinced that the treatment/services were unnecessary. Therefore, Respondent's denial cannot be upheld.

FEE SCHEDULE

Respondent argues that reimbursement for the services billed for should be reduced pursuant to the allowance of the Workers' Compensation Fee Schedule.

For date of service January 31, 2024, Applicant, a surgical center located in the State of New Jersey billed for its services pursuant to NJS CPT codes: 29821 (\$5677.77), 29823(59) (\$1472.45), 29825(59) (\$1472.45), 2 units of 29999(59) (\$1472.45 per unit), 64415 (\$979.78) and 76942TC(59) (\$341.96).

In support of its Fee Schedule argument, Respondent submitted the affidavit by Jeffrey Futoran, CPC, who identifies himself as a certified professional coder. Mr. Futoran's affidavit analyzes the Applicant's bill according to his interpretations of the requirements of the New York Worker's Compensation Fee Schedule and the New Jersey Workers' Compensation Fee Schedule. The gist of his argument is that proper reimbursement for the billed services is the lesser fee when calculated pursuant to the New York or the New Jersey formulation. That in this instance, the New Jersey formulation resulted in a lower fee. That Applicant improperly applied modifier -59 to its billing. That pursuant to the NCCI edits, CPT codes 29821, 29825 and 64415 may not be billed together with CPT 29823. Therefore, Applicant is not entitled to any reimbursement for CPT codes 29821, 29825 and 64415. That CPT codes 29999 and 76942 are not listed with a charge in the ASC column of the Fee Schedule and they are therefore not reimbursable to an

ACS facility. Mr. Futoran concluded that total reimbursement for the billed services was \$1472.45.

In response, Applicant submitted the Affidavit of Aaron Perretta, Esq., CPC, also a certified professional coder. Mr. Perretta argues that the New York EAPG framework applies as the EAPG framework yields a lesser rate of reimbursement than the New Jersey Fee Schedule. Mr. Perretta argues that CPT 29821 was the main procedure code and should be reimbursed at 100% with capital add-on for a total of \$5677.77. He argues that all other codes should be reimbursed at 50% due to the addition of modifier - 59. Without the application of modifier - 59 to the other codes, they would be bundled into CPT 29821 and would not be entitled to reimbursement separately. Mr. Perretta also argues that CPT 76942TC was reimbursable at 100%, as it was the only radiological code. Mr. Perretta concluded that total reimbursement pursuant to the New York formulation was \$11,909.53. With respect to Mr. Futoran's New Jersey analysis, Mr. Perretta comments that Mr. Futoran did not include proper use of 3M Core Grouping Software to compute the fee. Mr. Perretta opines that under the New Jersey framework the fee would be 13,183.74.

I note that for reasons unexplained, Mr. Perretta's analysis of the New Jersey formulation included CPT values for each code that were higher than those on Applicant's bill. Under no circumstance would Applicant be entitled to more than what was billed. According to my calculation with the CPT values actually billed and Mr. Perretta's analysis, total reimbursement would be \$8881.62.

Analysis

An insurer who raises a fee schedule defense, "will prevail if it demonstrates that it was correct in its reading of the fee schedules." *Jesa Medical Supply, Inc. v. Geico Ins. Co.*, 2009 NY Slip Op. 29386, 25 Misc.3d 1098, 887 N.Y.S.2d 482 (Civ. Ct. Kings Co. 2009). The burden of proving a fee schedule defense falls on the Respondent.

I find some of Applicant's analysis of the billing to be more informative and more persuasive than Respondent's. However, after a thorough review of the evidence it appears that use of the New York Fee Schedule framework would result in the lowest fee. I find that Applicant improperly applied modifier-59 to its billing. That CPT 29821 was reimbursable at 100%. That all other APG 37 codes were bundled into CPT 29821 and were not separately reimbursable. That CPT 76942TC was reimbursable at 100%. Based upon my calculation proper reimbursement is \$6019.73

Accordingly, I find for Applicant as follows.

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
	Surgicore Of Jersey City, LLC	01/31/24 - 01/31/24	\$11,567.57	Awarded: \$5,677.77
	Surgicore Of Jersey City, LLC	01/31/24 - 01/31/24	\$1,321.74	Awarded: \$341.96
Total			\$12,889.31	Awarded: \$6,019.73

- B. The insurer shall also compute and pay the applicant interest set forth below. 07/02/2024 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). The Superintendent and the New York Court of Appeals has 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).

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 Erie

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

01/19/2025
(Dated)

Tasha Dandridge-Richburg

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:
82f26cb8ae7c5a61d17b22d3192c8d74

Electronically Signed

Your name: Tasha Dandridge-Richburg
Signed on: 01/19/2025