

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

New York Medical Monitoring PC
(Applicant)

- and -

State Farm Mutual Automobile Insurance
Company
(Respondent)

AAA Case No. 17-24-1361-8317

Applicant's File No. none

Insurer's Claim File No. 52-30N0-44K

NAIC No. 25178

ARBITRATION AWARD

I, James Hogan, 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/claimant

1. Hearing(s) held on 02/14/2025
Declared closed by the arbitrator on 02/14/2025

Michael Galeno from Dino R. DiRienzo Esq. participated virtually for the Applicant

Craig Stabenau from Sarah C. Varghese & Associates participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$3,254.56**, 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, a 41 year old woman was allegedly injured in an MVA on 2/9/22. Applicant is billing for intra-operative monitoring the claimant who had surgery on 3/13/24. As per the AR-1, Applicant billed \$6,651.90; Respondent paid \$3,397.34, leaving an amount in dispute of \$3,254.56. Respondent contends that it reimbursed the Applicant pursuant to the fee schedule. Applicant has not filed a fee audit but has uploaded copies of arbitration decisions which support its position. Conversely, the Respondent has uploaded a fee audit by Ms. Cole, a CPC, who opines that the Respondent actually overpaid the Applicant and that the Applicant's billing was not accurate in that there was

no modifier indicating whether the service provided was for the professional component or the technical component. The reports indicate that there was a technician monitoring the patient.

4. Findings, Conclusions, and Basis Therefor

This decision is based upon my review of the electronic file maintained by the American Arbitration Association, and the arguments of the parties set forth in the hearing.

Applicant's submission:

Applicant is billing for services provided to the EIP on 5/13/24 in the form of intra-operative monitoring. Applicant billed under CPT code 95941, 95939, 95938 and 95861.

As per the AR-1, Applicant billed \$6,651.90; Respondent paid \$3,397.34, leaving an amount in dispute of \$3,254.56.

In addition to its billing, the Applicant has provided:

A copy of Respondent's NF-10 dated 4/15/24 in which the Respondent made a partial payment. As per the EOB:

CPT code 95941 - continuous intraoperative neurophysiology monitoring - billed at \$4,581.70. Respondent paid \$1,327.14,

CPT code 95939 - central motor evoked potential study in the upper and lower limbs billed at \$1,070.03. Respondent reimbursed the Applicant as billed.

CPT code 95938 - short latency somatosensory evoked potential study, billed at \$683.79. Respondent reimbursed the Applicant as billed.

CPT code 95861 - needle EMG, 2 extremities, billed at \$316.38. Respondent reimbursed the Applicant as billed.

The reason for the reduced payment for CPT code 95941 is that this CPT code was derived from CPT code 95940 x 18 units, each unit billed at 15 minute intervals, with the total amount being 4 hours and 24 minutes. As per the NY Fee Schedule and By Report guidelines, the total reimbursement should be \$1,327.14. This document indicates "Hookup Time" as 0938 and the patient was out of the ER at 1402.

A copy of a report reflecting the monitoring of the EIP during the surgery has also been provided.

In a Supplemental Submission uploaded by the Applicant on 1/3/25, there are a number of arbitration decisions.

The first decision is case number 17-23-1294-7399, between the Applicant in the Respondent regarding intraoperative monitoring of a different claimant. The claimant had surgery in the form of an anterior cervical discectomy and fusion. The monitoring was done from outside the operating room. Applicant billed \$4,581.70 for the intraoperative monitoring utilizing CPT code 95941 in connection with the anterior cervical discectomy and fusion. This code is described as

"continuous intraoperative neurophysiology monitoring, from outside the operating room

(remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)." Respondent paid the Applicant \$1,105.89 and denied the amount at issue stating that the reimbursement amount was calculated in accordance with the Worker's Compensation Fee Schedule and that the reader of the denial was referred to "the attached." The Arbitrator said that whatever was attached was not evident from the record.

Respondent submitted a fee audit from Mercy Acuna, a registered nurse and a CPC. She opined that the proper reimbursement for CPT code 95941 was \$700.44, not \$1,105.89, as paid by the Respondent. The relative value of CPT code 95941 is indicated as "BR" meaning "by report." General Ground Rules contained in the fee schedule indicate that a "by report" item represents a service that is too variable in nature of his performance to permit assignment of a unit value. Respondent therefore was required to request verification from the Applicant to assess the value of the services if it questioned the charges on the Applicant's claim **Bronx Acupuncture Therapy, PC v. Hereford Ins. Co.**, 54 Misc 3d 135(A). There is no indication in the record that this was done. Moreover, Ms. Acuna arrived at her allowable amount by changing the billed code to 95940. However, that code is for monitoring while inside the operating room. Ms. Acuna fails to provide any rationale as to why she changed the code and what records demonstrated that monitoring occurred inside the operating room instead of remotely as billed by the Applicant. The reduction therefore cannot be sustained. The claim was awarded in the amount of \$3,475.81.

Case number 17-22-1251-3625 is between the same parties for the same services were provided to a different claimant. This matter was heard by Arbitrator Lisa Abrams 18/31/23. In her decision Arbitrator Abrams says "I find that when the calculation of the proper fee for a particular service or procedure is clearly set forth in the schedule, an interpretation of the fee by a qualified professional is not required. However, when there is more than one reasonable interpretation of the proper fee for a particular service rendered, and interpretation by a qualified professional is required. This dispute involves a By Report code 95941. A BR code involves taking into consideration a number of factors such as the appropriate fees and the relative value units which are to be

determined based upon the nature, extent and the need for the procedure, and the time, skill and equipment necessary to provide the service, which, in my opinion, a professional needs to interpret because they may be more than one interpretation."

She then reviews the fee audits of both parties. She agrees with the position of the Applicant's coder who opined that the Respondent's coder engaged in an impermissible crosswalk between the 2 CPT codes. She found in favor of the Applicant.

I note that there are other arbitration decisions where the opinion of the Respondent's coder is challenged in the various arbitrators found in favor of the Applicant. I note that in some of those cases the decision was based upon the Applicant's fee audit by a CPC.

Respondent's submission:

Respondent's position is set forth in counsel's letter dated 10/24/24. Counsel argues that the Respondent properly reimbursed the Applicant for the services provided. The only CPT code that is in dispute is 95941. Counsel refers to General Ground Rule #3, which deals with BR codes and the fact that the physician is charged with demonstrating the reimbursement billed under that code.

Respondent's counsel argued that the documentation showed that the monitoring occurred for 4.24 hours, which converts to 18 units. CPT code 95940 carries 6.66 RVUs. The conversion factor is \$73.73. Multiplying the conversion factor by the number of RVUs, the reimbursement comes to \$1,327.14, which is the amount paid.

Respondent relies upon an affidavit by a CPC. I note that this affidavit was uploaded after the Respondent's response to the arbitration was filed. It was in a supplemental submission uploaded on 11/15/24.

The Respondent has also provided a copy of the Applicant's billing and its corresponding NF-10 which was issued on 4/15/24. (see above)

The Respondent has also provided copies of pages from the NYS WCB Medical Fee Schedule.

In a Supplemental Submission uploaded by the Respondent on 11/15/24, there is a report from Jodi Cole, L.A., CPC, of Signet Claim Solutions, LLC.

Ms. Cole provides a background and training and has been coding for over 14 years. She lists the records that she has reviewed.

She has generated a chart which lists the CPT codes that were billed by the Applicant for DOS 3/13/24. This is accompanied by the amount billed, the definition of the CPT code, the "Correct CPT Code" the "Correct Reimbursement" and the "Rationale."

In this chart Ms. Cole indicates that CPT code 95941 should have been billed under CPT code 95940 and reimbursed in the amount of \$516.11.

CPT code 95939, which was billed at \$1,007.03, should have been billed under CPT code

95939-26 it reimbursed at \$267.51.

CPT code 95938, which was billed at \$683.79 should have been billed under CPT code 95938-26 and reimbursed in the amount of \$102.57.

CPT code 95861 which was billed at \$316.38 should have been billed under CPT code 95861-26 in the amount of \$226.24.

As per the chart, the "Correct Reimbursement" totals \$1,112.73.

In the "Summary" section of her report, Ms. Cole refers to the NYS WCB Medical Fee Schedule Introduction and General Guidelines. She also refers to the CPT Assistant and the CPT Book, as well as instructions for the Use of the CPT Book.

She then describes CPT codes 95940 and 95941 saying that they describe ongoing neurophysiological monitoring, testing and data interpretation distinct from the performance of a specific type(s) of baseline neurophysiological study(s) performed during surgical procedures. When the services performed by the surgeon or anesthesiologist, the professional services are included in the surgeon's or anesthesiologist's primary service code(s) for the procedure and are not reported separately.

Recording and testing are performed either personally or by a technician who was physically present with the patient during the service. Supervision is performed either in the operating room or by real-time connection outside the operating room. The monitoring professional must be solely dedicated to perform the intraoperative neurophysiological monitoring and must be available to intervene at all times during the service as necessary, for the reported time period(s) 4 any given period of time spent involving the services, the service takes full attention and therefore, other clinical activities beyond providing and interpreting of monitoring cannot be provided during the same period of time.

"Throughout the monitoring, there must be provisions for continuous and immediate communication directly with the operating room teams in the surgical suite. One or more simultaneous cases may be reported (95941). When monitoring more than one procedure, there must be the immediate ability to transfer patient monitoring to another monitoring professional during the surgical procedure should that individual's exclusive attention be required for another procedure. **Report 95941 for all remote or non-one-on-one monitoring time connected to which case regardless of overlap with other cases.**"

As per Ms. Cole, these 2 CPT codes include ongoing neurophysiological monitoring time. Distinct from performance of specific types of baseline neurophysiological studies were other services such as intraoperative functional cortical or subcortical mapping. The CPT codes, 95940 and 95941, are reported based upon the time spent monitoring only. Additionally, the same neurophysiological studies performed at baseline should be reported not more than once per operative session.

She then says that CPT code 95940 requires reporting only the portion of time the mounting professional was physically present in the operating room.

CPT code 95941 should be used once per hour even if multiple methods of neurophysiological monitoring are used during that time. This code requires monitoring of neurophysiological data that is collected from the operating room continuously on-line in real time via a secure datalink. While reporting 95941, real-time ability must be available through sufficient data bandwidth transfer rates to view and interrogate the neurophysiological data contemporaneously.

Referring to the claimant in this case, Ms. Cole says "Report 95941 for all cases in which there was no physical presence by the monitoring professional in the operating room during the monitoring time or when monitoring more than one case in an operating room. It is also used to report the time of monitoring physically performed outside of the operating room in those cases where monitoring occurred both within and outside the operating room. Do not report 95941 if the monitoring last 30 minutes or less. Intraoperative neurophysiology monitoring codes 95940 and 95941 Re: choose to report the total duration of respective time spent providing each service, even if that time is not a single continuous block." She credits the AMA for this statement.

Ms. Cole then list the CPT codes utilized by the Applicant and refers to General Ground Rule #3 with regard to the criteria for a BR code. She notes that for any procedure where the relative value unit is listed in the schedule as "BR," the physician shall establish a relative value unit consistent in relativity with other relative value units shown in the schedule. The insurer shall review all submitted "BR" relative value units to ensure that the relativity consistency is maintained. The general condition of the requirements of the General Ground Rules apply to all "BR" items.

She then refers to the CPT Assistant Newsletter dated May 2013, "Intraoperative neurophysiological monitoring (IONM) is defined as the use of electrophysiological methods to monitor the functional integrity of certain neural structures (eg, nerves, spinal cord and parts of the brain) during surgery..."

Over the years technological developments have changed the way that the services are provided. CPT code 95920 and the instructional parenthetical note following code 95920 were deleted in CPT 2013 as it was unclear as to whether monitoring must occur and how many cases may be simultaneously monitored.

Two and-on codes (95940, 95941) were established in CPT 2013 to better reflect current practice when providing IONM services. Code 95940 describes continuous IONM

requiring personal attendants from inside the operating room. Code 95941 describes continuous IONM that can be provided remotely from outside the operating room and for cases that are monitored simultaneously with other operative cases. Additionally, new guidelines have been added to clarify the appropriate use of the codes for intraoperative monitoring.

Ms. Cole then refers to the split between the professional component and the technical component of the CPT codes.

She refers to the Applicant's billing under CPT code 95941 which was billed in the amount of \$4,581.70. she reiterates the definition of this CPT code and says that according to the fee schedule, this is a BR code indicating the provider should indicate what service within the medical fee schedule is comparable to a specific relative value. **This was not provided.**

Since the provider neglected the supplier procedure with a comparable relative value, the comparable/reference code closest in description to CPT code 95941 is 95940. The difference is the location of the monitoring and that one is within the operating room while the other can be done remotely. CPT code 95940 refers to continuous monitoring in the operating room and the reimbursement rate is in 15 minute intervals.

She then calculates the professional time for the monitoring and concludes that it amount to 1:50 minutes. Therefore, the accurate reimbursement under CPT code 95940 is \$516.11 which is calculated by taking 6.66 RVUs multiplied by the conversion factor of \$11.07 giving you \$73.73. Multiply this by the number of units (time in 15 minute intervals) gives you 7 units multiplied by \$73.73 for a total of \$516.11.

Ms. Cole also notes that the provider billed for CPT codes 95939, 95938 and 95861. All of those codes have both the professional component in a technical component. The modifier for the professional coder is-26 and the modifier for the technical component is-TC. She opines that based upon the procedure report, the technical portion was assigned to IONM to John Conway. The professional component should be billed by Dr. Alan Ettinger.

Ms. Cole then calculates the reimbursement for CPT codes 95939, 95938 and 95861 utilizing the split and calculating the reimbursement for the technical component.

I note that she indicates the split as PC/TC and then lists the amount of the split as 25/75, 15/85 or 80/20, respectively for each of the aforementioned CPT codes. She then calculates the reimbursement and says that CPT code 95939 should be paid at 25% which would be the technical component; CPT code 95938 should be paid 15% again, the technical component and CPT code 95861 should be paid at 80% but this is listed as the professional component.

She concludes that the total reimbursement should be \$1,112.73. she opined that the Respondent overpaid the Applicant by \$2,284.61.

At the hearing:

Applicant relied upon the arbitration decision from Arbitrator Rybicki (see above) and argued that the Respondent should have issued a request for additional verification.

Applicant also argued that other than CPT code 95941, the Respondent reimbursed the Applicant for the other CPT codes as billed.

Respondent argued that the Respondent properly reimbursed the Applicant pursuant to CPT code 95940 based upon the criteria set forth in General Ground Rule #3. The Applicant failed to demonstrate the criteria listed in that General Ground Rule - in that it did not demonstrate the basis for its calculation.

Findings:

Pursuant to Insurance Regulation 65-4.5(o) "the arbitrator shall be the judge of the relevance and materiality of 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."

Applicant has established its prima facie case.

Applicant is billing for intra-operative monitoring the claimant who had surgery on 3/13/24. As per the AR-1, Applicant billed \$6,651.90; Respondent paid \$3,397.34, leaving an amount in dispute of \$3,254.56.

Respondent contends that it reimbursed the Applicant pursuant to the fee schedule.

Applicant has not filed a fee audit but has uploaded copies of arbitration decisions which support its position.

Conversely, the Respondent has uploaded a fee audit by Ms. Jodie Cole, a CPC, who opines that the Respondent actually overpaid the Applicant and that the Applicant's billing was not accurate in that there was no modifier indicating whether the service provided was for the professional component or the technical component. The reports indicate that there was a technician monitoring the patient.

The definition of General Ground Rule #3 is "By report (BR) items: "BR" in the Relative Value column represents services that are too variable in nature of their performance to permit the assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill in the equipment necessary etc. is to be furnished. A detailed clinical record is not necessary but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records, hence the importance of documentation. The original official record, such as operative report and hospital chart, will be given for greater weight than supplementary reports formulated and submitted at a later date. For any procedure with the relative value unit is listed in the schedule as "BR," the physician shall establish a relative value

unit consistent in relativity with other relative value units shown in the schedule. The insurer shall review all submitted "BR" relative value units to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items.

I note that the Respondent issued its NF-10 on 4/15/24. Therefore, at that point in time the Respondent had made his determination as to the reimbursement amount for the Applicant.

Respondent reimbursed the Applicant as billed for 3 of the 4 CPT codes. It made a reduced payment for CPT code 95941 saying that this CPT code was derived from CPT code 95940 x 18 units each unit is 15 minutes of time for a total of 4 hours and 24 minutes. The Respondent paid \$1,327.14, against billing in the amount of \$4,581.70.

The report from Ms. Cole was uploaded on 11/15/24, 7 months after the Respondent issued its NF-10.

I have to agree with my colleague, Arbitrator Rybicki, and that if the Respondent had any question regarding the correctness of the Applicant's billing, it should have issued a request for additional verification.

Respondent 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.,

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). See, also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co., 1 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). When an insurer fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, the insurer's defense of noncompliance with the appropriate fee schedules cannot be sustained. Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Tm, 1st Dep't, per curiam, 2006). An insurer may interpose a defense in a timely denial that the claim exceeds the fees permitted by the Workers' Compensation schedules, but the insurer must, at least, establish, by evidentiary proof, that the charges exceeded that permitted by law. Abraham v. Country-Wide Ins. Co., 3 Misc.3d 130A, 787 N.Y.S.2d 678, 2004 NY Slip Op 50388U, 2004 N.Y. Misc. LEXIS 544 (App. Tm, 2nd Dep't 2004).

Respondent's defense is based on the fee schedule. Respondent "down-coded," or "recoded" payment based upon its own and arbitrary interpretation of applicant's services. This change, i.e. choosing a CPT code different from the CPT code chosen by Applicant and choosing a CPT code with a lower fee than the CPT code chosen by Applicant, was made without a supporting medical opinion, or certified billing coder report. A layperson is not qualified to evaluate the CPT codes or to change the codes used by a health provider in its bills.

In Gaba Medical, P.C. v. Progressive Specialty Ins. Co., 36 Misc.3d 139(A), 2012 N.Y. Slip Op. 51448(U), (App. Term 2d, 11th & 13th Dists. July 25, 2012). CPT Code 97750 is a time-based code -- a maximum permissible charge of \$41.66 applies to self-employed physical therapists in the New York City region for each 15 minutes -- and there is no rational basis for Respondent's unilateral assumption that 60 minutes was spent on the service, an assumption which led Respondent to make partial payment of \$83.31. Respondent did not seek additional verification as to the time spent on these dates, so the unilateral partial payment cannot be sustained on the stated ground that CPT Code 97750 applied. This asserted defense of Respondent does not defeat Applicant's prima facie case.

Although the services in the Gaba Medical case are different from the services in the instant case, the issue is the same in that if there is a question as to the proper billing, the Respondent should have requested additional verification from the Applicant.

The Respondent did not rely upon the fee audit of Ms. Cole, as it was uploaded 7 months after the Respondent issued its denial.

After a review of the documentation contained in the file and listening to the arguments of the parties at the hearing, I find in favor of the Applicant.

The claim is awarded.

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.

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Medical		From/To	Claim Amount	Status
	New York Medical Monitoring PC	03/13/24 - 03/13/24	\$3,254.56	Awarded: \$3,254.56
Total			\$3,254.56	Awarded: \$3,254.56

- B. The insurer shall also compute and pay the applicant interest set forth below. 08/21/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

I find that the date for interest to accrue is the date of the filing of the arbitration, 8/21/24 as this is the date when the Applicant's filing was processed and notice of the arbitration sent to the Respondent. As per Insurance Regulation 65-3.9, interest is due until such amount is paid, and without demand therefore.

C. Attorney's Fees

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

The insurer shall pay the Applicant's attorney as per 11 NYCRR 65-4.6 (e). However, if the award and interest is equal to, or less than, Respondent's written offer during the conciliation process, then the attorney's fee shall be based upon 11 NYCRR 65-4.6 (b).

- 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 WI

SS :

County of Waukesha

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

02/14/2025
(Dated)

James Hogan

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:
92fe68c9ad15ee0b3e01d1d3fcad5bc1

Electronically Signed

Your name: James Hogan
Signed on: 02/14/2025