

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

United Medical Monitoring PC
(Applicant)

- and -

Nationwide Affinity Insurance Company Of
America
(Respondent)

AAA Case No. 17-24-1361-8301

Applicant's File No. none

Insurer's Claim File No. 865768-GH

NAIC No. 26093

ARBITRATION AWARD

I, Mona Bargnesi, 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: Assignor ["DR"]

1. Hearing(s) held on 02/11/2025
Declared closed by the arbitrator on 02/11/2025

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

Gina Spiteri, Esq. from Law Offices of Brian Rayhill participated virtually for the
Respondent

2. The amount claimed in the Arbitration Request, **\$4,539.49**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant agreed to amend the amount in dispute downward to **\$1,042.38** to reflect a prior payment made as well as the undisputed EAPG amount.

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

3. Summary of Issues in Dispute

This case arises out of a motor vehicle collision which occurred on September 13, 2018. The 59 year-old restrained passenger allegedly injured her neck, back and shoulder.

The issue is whether Applicant is entitled to reimbursement for services provided during lumbar discectomy performed on March 14, 2024.

Respondent denied reimbursement on the basis that the amount billed exceeds the fee schedule.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the submissions contained in the American Arbitration Association's ADR Center as of the date of the hearing. These submissions are the record in this case.

William Capicotto, MD, performed lumbar discectomy on March 14, 2024; Applicant provided medical monitoring services.

The only code in dispute is 95941.

Respondent must demonstrate by "competent evidentiary proof" that applicant's claims were in excess of the appropriate fee schedules, otherwise respondent's defense of noncompliance with the appropriate fee schedule cannot be sustained. Continental Medical, P.C. v. Travelers Indemnity Co., 11 Misc. 3d.145A (App. Term 1st Dept. 2006).

It provided the Affidavit of Russell Arnold, CPC, explaining his calculations of the appropriate EAPG amounts. noting that 95941 is a By Report (BR) code, and explaining that code 95940 is defined as "continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes" and is the most relative CPT code listed in the fee schedule. The coder also noted that code 95941 is to be billed once for each hour, and further explained that here, the total time was 57 minutes.

In rebuttal, Applicant submitted an affidavit by Priti Kumar, CPC, stating, Code 95941 is one of the codes that was intentionally listed without an RVU and was listed as a "by report" code. To crosswalk code 95941 (a BR code) to code 95940 (a code with RVU 6.66) would run counter to the Workers' Compensation Board's intention to specifically assign an RVU to one code but not the other, particularly since the two codes are listed right next to each other." [emphasis in original].

I find the Affidavit of Coder Arnold to be more persuasive than that of Ms. Kumar. I hereby adopt and incorporate the sound reasoning of my fellow Arbitrator Fred Lutzen (*see* AAA #17-22-1273-5774), as follows:

In the first instance, it is noted that the two CPT Codes are almost identical. The primary differences are that 99540 is billed for 'one-on-one' monitoring by

personal attendance, billed in 15-minute intervals, and 95941 is billed for remote monitoring, billed per hour, and the provider may monitor and bill multiple patients or procedures simultaneously.

Coder Kumar does not offer any persuasive explanation for why remote monitoring would be valued 60 times greater than in-person 'one-on-one' monitoring in the operating room. Additionally, Respondent did not simply 'cross-walk' the charge to a different code. Respondent's coder used code 95940 as being consistent in relativity as a comparison code since the services are similar. It is more logical that the RVU of code 95941 would be lower than 95940 not higher since 95940 is 'one-on-one' in-person, while 95941 can be remote and billed to multiple patients at the same time. It is simply illogical that it would be billed 60-times greater than the 'one-on-one' in-person service. After comparing the two coding analyses, Coder [Mallory]'s comparison to code 95940 is logical and demonstrates a unit value consistent in relativity with other units shown in the fee schedule while Applicant's proposal is not consistent with any service remotely close to the service performed in this case. Coder [Mallory]'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 Kumar is unpersuasive and failed to rebut the opinion by Coder [Mallory].

Respondent's denial is upheld.

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 Erie

I, Mona Bargnesi, 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)

Mona Bargnesi

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:
2d1f57bba1760bb32b07a88014e4bfce

Electronically Signed

Your name: Mona Bargnesi
Signed on: 02/14/2025