

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Progressive Surgical Center
(Applicant)

- and -

Plymouth Rock Assurance Preferred
Corporation
(Respondent)

AAA Case No.	17-25-1386-7083
Applicant's File No.	3426163
Insurer's Claim File No.	813602463236-002
NAIC No.	36587

ARBITRATION AWARD

I, Paul Weidenbaum, 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: IP

1. Hearing(s) held on 08/26/2025
Declared closed by the arbitrator on 08/26/2025

Ryan Berry from Israel Purdy, LLP participated virtually for the Applicant

Stamatis Michelakos from Law Office of Joseph C. Sette & Associates participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$147,902.18**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount claimed in No-Fault benefits was amended during the arbitration hearing from \$147,902.18 to \$1,991.75 [the differential between the allowable rate of \$5,812.57 and the previously reimbursed sum of \$3,820.82] in order to conform to the Applicant's interpretation of the applicable provisions of the fee schedule, and the amendment was permitted by this arbitrator.

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

3. Summary of Issues in Dispute

This arbitration arises out of a surgical procedure undergone by the injured person, a 24 year old male [A.R.], who was involved in a motor vehicle accident which occurred on 7/9/24.

Whether Respondent's reduction/denial of the Applicant's claim for reimbursement of No-Fault benefits based on fee schedule can be sustained?

4. Findings, Conclusions, and Basis Therefor

This arbitration arises out of a surgical procedure undergone by the injured person, a 24 year old male [A.R.], who was involved in a motor vehicle accident which occurred on 7/9/24. Applicant initially sought reimbursement in the sum of \$147,902.18. However, during the 8/26/25 hearing, Applicant's counsel amended the amount claimed in No-Fault benefits to \$1,991.75, the differential, between the Applicant's interpretation of the allowable rate based on the applicable fee schedule provisions [\$5,812.57] and the amount previously reimbursed by the Respondent [\$3,820.82].

Respondent maintains that, even as amended, the amount sought by Applicant in additional reimbursement exceeds the allowable rate of reimbursement. In support of its fee schedule defense, the Respondent has submitted the thirteen (13) page fee audit prepared by Jennifer Comunale, C.P.C. dated 3/19/25, in which Ms. Comunale concluded that no additional reimbursement is due because the total allowable rate of reimbursement for the facility fee in connection with the 10/11/24 surgical procedure is \$3,026.24, and the Respondent already reimbursed \$3,820.82, which means the carrier actually overpaid the allowable rate for the services at issue by \$794.58.

The full contents of Ms. Comunale's Fee Audit of 3/19/25 are hereby incorporated herein.

In refutation of the conclusions set forth in the Comunale Fee Audit, the Applicant has submitted the fee analysis prepared by Priti Kumar, C.P.C. dated 4/17/25, in which Ms. Kumar attests as follows:

1. I am a professional coder. My Certification# is 01132854.

2. The purpose of this affidavit is to determine the ASC fee payable in accordance with prevailing fee schedule to Applicant - Progressive Surgical Center's billing for the left shoulder surgical procedures performed on 10/11/2024; and to refute the respondent's fee coder affidavit.

3. The services were performed at Applicant's facility located in Englewood CL, NJ 07632, a location that falls within the North Region of New Jersey Fee Schedule. The bill indicates that the patient is a resident of NY and thus according to 11 NYCRR 68(b), as amended via 33rd amendment, the amount the insurer shall reimburse for

the services shall be the lowest of: Highest applicable amount in the New York Fee Schedule, The amount charged by the provider; and The prevailing fee in the geographic location of the provider.

4. The following chart demonstrates Applicant's billing for the ASC fee for services performed on DOS at issue, and Fee payable as per NJ FS and EAPG Methodology for each of the billed Code: CPT code Billed Amount NJ Fee schedule Rate EAPG Methodology Group Rate 29820-LT \$49,812.00 \$6,462.39 \$2944.87 29823-LT-59 \$33,709.00 \$6,462.39 \$2944.87 29826-LT-59 \$32,968.00 \$6,462.39 \$2944.87 29805-LT-59 \$16,700.00 \$3,997.71 \$2944.87 20610-LT-59 \$9,346.00 \$157.95 \$473.38 0232T-LT-59 \$9,028.00 \$89.55 \$875.92 P9020 \$160.00 Invoice rate \$875.92 \$51,723.00 # Plus capital add-on payment for ASC facility fee of \$81.37

5. Respondent's fee coder while calculating fee as per NJ ASC fee schedule allowed total amount of \$16,155.98; and while calculating fee as per EAPG Methodology adopted by NY WC Fee Schedule allowed total amount of \$3,026.24. There is no dispute that in the instant case the ASC fee prescribed as per EAPG methodology adopted by New York Workers' Compensation Fee Schedule for ASC's charges is less than the fee prescribed as per NJ Fee Schedule and the total billed amount; therefore, the bill at issue is payable at the fee prescribed by EAPG Methodology in compliance with 33rd amendment to 11 NYCRR 68. However, I am in disagreement with the recommendations done by Respondent's fee coder while calculating fee as per EAPG Methodology. Therefore, I proceed to discuss the proper ASC fee payable for bill at issue at per EAPG methodology adopted by NY WC FS:

6. According to 12 NYCRR 39-2.1, effective October 1, 2015, the Workers' Compensation Board adopted EAPG (Enhanced Ambulatory Patient Group) payment methodology implemented by the Department of Health in 2009 for determining fees for Ambulatory Surgery in New York. In the instant case, the date of service at issue is after the method of billing had been changed to the new EAPG system. The EAPG base rate of \$295.95 prescribed for downstate is the highest base rate and therefore it is applicable for the bill at issue pursuant to Clause (b)(1), which states, "The amount of the fee set forth in the region of this State that has the highest applicable amount in the fee schedule for that service." The capital add-on code for ASC is \$81.37.

*7. Under the EAPG system, the CPT/HCPCS codes are grouped into APG code groups according to the procedure and/or diagnosis. Each APG has an average weight based on the group's average cost. A weight multiplier is then applied to each APG as follow to result in a final "weight," * 100% for primary (highest weighted APG procedure) * 100% unrelated ancillaries * 150% for bilateral procedures * 50% for discounted lines (unrelated significant procedures performed in single visit).*

8. The EAPG group and EAPG rates for each of the code billed at issue are as under: Code EAPG Group EAPG Weight Base Rate EAPG Rate 29820 37 9.9509 \$295.94 \$2944.87 # 29823 37 9.9509 \$2944.87 29826 37 9.9509 \$2944.87 29805 37 9.9509 \$2944.87 20610 49 1.5996 \$473.38 0232T 113 2.9598 \$875.92 P9020 2061 2.9598 \$875.92 #Plus capital add-on for ASC fee of \$81.37

9. Regarding CPT code 29823: EOB dated 12/16/2024 indicated Respondent has allowed CPT Code 29823 partially at \$1,472.45 (50% of EAPG Group 37 Rate). Now, Respondent has provided the Fee Coder affidavit dated 03/19/2025 that allowed CPT Code 29823 at \$3,026.24. I do not dispute the fact that in the instant case as per EAPG Methodology Primary Significant Procedure of "Extensive Debridement" reportable under CPT Code 29823 is payable at \$3,026.24 (\$2,944.87 the EAPG Group 37 rate, plus capital add-on payment for ASC facility of \$81.37).

10. Regarding CPT Codes 29820, 29805 and 29826: As per the EAPG system, where multiple procedures are performed, payment pursuant to this section shall be based upon 100% of the group price for the highest priced procedure and 50% of the applicable group price for each additional distinct procedure furnished in the same operative session. Of note is that EOB dated 12/16/2024 indicated Respondent has allowed CPT Code 29826 partially at \$1,472.45 (50% of EAPG Group 37 Rate); and denied reimbursement for Codes 29820 and 29805. Now, contrary to this, Respondent has provided the Fee Coder affidavit dated 03/19/2025 that denied all three codes 29820, 29805 and 29826 on the grounds of 'consolidation' and that 'modifier not supported'. I am of opinion that the procedures of "diagnostic arthroscopy" reportable under Code 29805 is not separately billable, with other arthroscopic procedures performed on ipsilateral shoulder joint. Therefore, in the instant case Code 29805 is not separately payable. Furthermore, the operative report indicated additional procedures of "partial synovectomy" reported under Code 29820 is incidental to the procedures reported under code 29823 since the operative report indicated both these procedures were performed in glenohumeral joint, that is, the same compartment of the shoulder joint; although applicant has appended modifier 59 to code 29820, however the modifier is not supported by the operative report. Therefore, code 29820 not separately reimbursable. However, this is not the case with the CPT Code 29826. It is my opinion, that the in the instant case, as per EAPG Methodology and NCCI Edits, CPT code 29826 is payable separately along with primary procedure code 29823 for the reasons discussed below:

A. As per EAPG Methodology only significant procedures that are an integral part of the primary significant procedure and which can be performed with relative little additional efforts when performed with primary procedures are consolidated; however, additional unrelated significant procedures performed on the same date of services are not consolidated in the APG classification system, but payment for unrelated additional significant procedure will be discounted at 50% of the EAPG Group Rate.

B. Here, although the additional procedures under Code 29826 were performed in conjunction with the primary procedures under Code 29823. However, additional procedures reported under Code 29826 are not incidental to the significant procedure reported under Code 29823 which can be performed with relatively little additional effort.

C. Here, the operative report clearly indicated that the primary procedures of "Debridement" reported under Code 29823 were performed in Glenohumeral Joint. Whereas, the additional procedures of "Subacromial Decompression with Acromioplasty" reported under Code 29826 were performed in subacromial space, that is, the separate compartment of the shoulder joint and hence were significantly distinct procedures from the procedure reported under code 29823. As such, per the documentation the procedures reported under codes 29826 and 29823 are distinct and unrelated procedures; and therefore, for payment purposes both these procedures are not consolidated, rather separately payable.

D. It is pertinent to note that the procedure of Subacromial Acromioplasty is not a procedure commonly carried out as an integral part of a total service, which could be bundled into any other arthroscopic procedures. Here, the operative report has indicated the pre and post operative diagnosis of "Left Shoulder Impingement Syndrome" due to which require performing of the Subacromial acromioplasty procedures reported under add-on code 29826.

E. Of note is that effective January 1, 2020, the Centers for Medicare and Medicaid Services (CMS) deleted language from the National Correct Coding Initiative (NCCI) Policy Manual which previously stated that the shoulder is a single anatomic structure. See updated manual at link <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCIManual-Archiv>

Therefore, the shoulder should be recognized as four anatomic areas: glenohumeral, acromioclavicular, sternoclavicular and the bursal space. Approach to each of these spaces is unique and different excisions are required to access each space. These are identifiable with unique ICD10 codes and corresponding CPT codes. Here, as discussed above procedures reported under code 29826 and 29823 were performed in two separate compartments/ areas or regions of the shoulder joint as recognized by CMS and NCCI Edits, and as such the payment for code 29823 should not influence the coding of code 29826.

F. NCCI Edits and EAPG manual permits separate reimbursement for additional procedures when the procedures are distinct and separate (separate encounters, different surgeries, different sites or organ system, separate incisions). The operative report indicated that the procedures reported under Code 29826 were performed through lateral portal made through separate incisions. The operative report indicates that after completing the "extensive debridement" procedure in the glenohumeral joint; the surgeon has performed additional significant procedure "subacromial decompression with acromioplasty" (code 29826) through lateral portal made with separate incision. The operative report at the relevant part has indicated "We then turned our attention towards the left shoulder subacromial space. Under direct visualization, a standard anterolateral portal was created; being careful not to extend the incision 3 cm past the lateral aspect of the acromion... An ablation wand was used to prepare the undersurface of the acromion. Next, a bur was introduced and an acromioplasty was performed. The undersurface of the acromion appeared to look flat

with an abundant amount of space in Subacromial space." Thus, the distinct procedures of "Subacromial decompression with acromioplasty" were performed through anterolateral portals made with separate incisions, and hence qualified to be distinct and separate procedure. Therefore, there is no bar for billing and separate reimbursement for 29826 when billed with code 29823. - See the award in the matter of Surgicore of Jersey City, LLC v. Global Liberty Insurance Company of New York, AAA# 17-19-1121-3292 wherein separate payment was allowed for procedures performed through multiple incisions.

G. It is pertinent to note that NCCI Edits which is also the relevant part of the EAPG methodology do not bar billing of Code 29826 with Codes 29823. There is no NCCI Edits PTP Coding Pair of Code 29826 with Codes 29823. Per NCCI Edits, when code 29823 appears in column 1, Code 29826 does not appear in column 2 against it, and when 29826 appears in column 1, Code 29823 does not appear in column 2 against it. Thus, NCCI Edits do not bar billing of codes 29823 and 29826 together when procedure reported under these two codes are performed on ipsilateral shoulder joints. It is my opinion, although as discussed above NCCI Edits does not require the applicant to append modifier "59" to add-on Code 29826. However, I am of view that as per EAPG Methodology Guidelines in the instant case, applicant has appropriately billed Code 29826 with modifier '59'.

H. EAPG methodology provides that if certain modifiers turned on, it can cause consolidation to not be applied. Thus, if appropriate Modifier is appended to the code, the 3M software show separate payment to these additional significant procedures performed on the same day by the same individual. Thus, the unbundling power of Modifier "59" is supported by the New York State Workers' Compensation Board via the EAPG framework.

I am of view that although codes 29826 and 29823 share same EAPG Group 37 these two codes are properly unconsolidated from one another, by appending Modifier 59 to code 29826, rendering it as a distinct and separate procedure. There is no dispute that when Modifier 59 is used 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 in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

I. I am of view that it is not necessary for all or a combination of these requirements to be met for Modifier 59 to apply. In other words, if only one of those conditions is satisfied, e.g., different procedure or surgery, then Modifier 59 may be appended to the CPT code. In the instant case as discussed above the operative report clearly indicated that procedure of "Subacromial decompression with acromioplasty" reported under code 29826 was separate and distinct procedure performed in separate compartment of shoulder joint; thus, Modifier 59 was appropriately appended to code 29826, thereby resulting in discounting rather than consolidation for payment purpose.

J. There is no dispute that all medically necessary procedures should be performing at the same operative session. Therefore, surgeon has performed the distinct procedures reported under code 29823 and 29826 in separate compartments of shoulder joint at same operative session. It is not disputed that the marginal cost of providing a second additional distinct procedure to a patient during a single visit is less than the cost of providing the procedure itself; considering this scenario the EAPG methodology has provided the discounting of 50% on the EAPG Group Rate, while allowing reimbursement for such additional distinct procedures performed in same operative session. EAPG methodology provides: Discounting: Discounting refers to a reduction in the standard payment rate for an APG; the APG payment system applies discounting when multiple unrelated significant procedures are performed. Discounting recognizes that the marginal cost of providing a second procedure to a patient during a single visit is less than the cost of providing the procedure itself (e.g. the cost of doing two procedures at the same time is less than the cost of doing those same procedures at two different times).

Here, Respondent's fee coder has allowed primary procedures Code 29823 at 100% of EAPG Group 37 rate. Therefore, distinct additional significant procedures under Code 29826 is payable separately at 50% of EAPG group 37 rate. As referred in chart above Group 37 is payable at \$2944.87 (9.95909 x 295.94). Therefore, code 29826 is payable at \$1,472.45 (50% of \$2944.87, the EAPG group 37 rate).

11.Regarding CPT Code 0232T: Applicant billed Code 0232T to report PRP injection. EOB indicated Respondent has allowed Code 0232T at \$875.92 (100% of EAPG Group Rate). Now, Respondent has provided the Fee Coder affidavit dated 03/19/2025 that denied reimbursement for CPT Code 0232T relying on the CPT Assistant. I am in disagreement with the denial of Code 0232T. It is my opinion that as per EAPG Methodology and NCCI Edits applicant is entitled for separate payment for Code 0232T along with Code 29823 for the reasons discussed below: A. As referred in the chart at Para 8 above, Code 29823 is assigned in EAPG Group 37. Whereas, Code 0232T is assigned in EAPG Group 113; and as per EAPG Methodology the EAPG group 113 is not consolidated into EAPG Group 37. As per EAPG methodology Consolidation: Refers to the collapsing of multiple related significant procedure EAPGs into a single EAPG for the purpose determining the payment.(See Appendix E -EAPG Consolidation at link.

https://www.health.ny.gov/health_care/medicaid/rates/bundling/2020/docs/2020-03-15-v4_apg_consolidation.pdf

B. Furthermore, Respondent has also overlooked the fact that NCCI Edits which is also the relevant part of the EAPG methodology do not bar billing of Code 0232T with Codes 29823. There is no NCCI Edits PTP Coding Pair of Code 29880 with Code 0232T. Per NCCI Edits, when code 29823 appears in column 1, Code 0232T does not appear in column 2 against it. Similarly, when code 0232T appears in column 1, Code

29823 does not appear in column 2 against it. Thus, NCCI Edits do not bar billing of codes 29823 and 0232T together when procedure reported under these two codes are performed on ipsilateral shoulder joint.

C. As per EAPG Guidelines on "Significant Procedures: Consolidation and Discounting": Multiple unconsolidated significant procedure EAPGs' on same day fall under discounted price. The highest weighted EAPG (29823) is paid at 100% and the EAPGs' with lesser weighted (0232T) amount that are not consolidated are paid at 50%. Therefore, additional procedures reported under code 0232T is payable at 50% of the EAPG group rate. As discussed in the chart at Para 8 above, the EAPG weight assigned to EAPG Group 113 is 2.9598; thus EAPG Group 113 Rate is \$875.92 (295.94 x 2.9598). Thus, applicant is entitled to amount of \$437.96 (50% of \$875.92 EAPG Group 113 Rate). D. See the award in the matter of New Horizon Surgical Center LLC v. State Farm Mutual Automobile Insurance Company AAA# 17-20-1157-2239, wherein arbitrator Laura Yantsos awarded Code 0232T (PRP) at \$437.96 separately along with Code 29880 (knee surgery) . The Arbitrator specifically noted: "Code 0232T has a different APG score and a separate and distinct procedure (plasma rich platelet injection) from the arthroscopic surgery performed, and therefore is reimbursable without inputting Modifier 59. Having found that the overall bill is lower is New York, I find that the New York EAPG schedule should be utilized on the entire bill. For this service, the Applicant is entitled to charges of \$437.96". Page No: 13 AAA# 41-25-1386-7083 Patient: Andrew Russell DOA: 07/09/2024 DOS: 10/11/2024 Also see award in the matter of SCOB LLC v. Allstate Fire & Casualty Insurance Company AAA# 17-22-1255-6971, wherein Arbitrator Thomas Awad has allowed Code 0232T (PRP) separately along with Code 29898 (ankle surgery) when billed with arthroscopic procedure code. I am of view while above referred awards pertain to billing of Code 0232T along with Code 29880 (knee surgery) and Code 29898 (ankle surgery) the same logic may be applied to Code 29823 (shoulder surgery).

12.Regarding Code P9020: Applicant has appropriately billed Code P9020 to report preparation of 'platelet rich plasma' for PRP injection reported under Code 0232T separately. As referred in the chart at Para 8 above, CPT Code P9020 is assigned in EAPG Group 2061. Per EAPG Methodology EAPG Group 2061 is described as "Class I Blood Products" falls under EAPG category 'Blood product' As discussed in the chart at Para 8 above, the EAPG weight assigned to EAPG Group 2061 is 2.9598; thus EAPG Group 20610 Rate is \$875.92 (295.94 x 2.9598).

Thus, applicant is entitled to amount of \$875.92.

13.In view of foregoing the ASC fee payable for the services at issue as per EAPG methodology adopted by NY WC fee schedule is as under: CPT Code EAPG group EAPG Rate Payable Remark 29823-59 37 \$2944.87 \$3,026.24 Primary significant procedure payable at 100% of EAPG rate plus Capital Add-on Payment of \$81.37

29826-59 37 \$2944.87 \$1,472.45 Additional significant distinct procedure reported under addon Code performed in separate compartment of shoulder joint payable at 50% of EAPG rate. 29820-59 37 \$2944.87 \$0.00

No separate payment when billed with other arthroscopic procedures as per EAPG methodology consolidated. 29805-59 37 \$2944.87 \$0.00 20610-59 49 \$473.38 \$0.00 0232T 113 \$875.92 \$437.96 Additional significant procedures in unconsolidated EAPG group are payable at 50% of EAPG Group Rate P9020 2061 \$875.92 \$875.92 Separate EAPG Category Group payable as per EAPG Group Rate Total \$5,812.57

14. In conclusion, EOB indicated Respondent has allowed bill partially at \$3,820.82. Therefore, subject to proper payment proofs for the amount of \$3,820.82; as per EAPG Methodology the Applicant is entitled to additional amount of \$1,991.75 (\$5,812.57 - \$3,820.82) towards ASC fee for shoulder surgical procedure performed on DOS at issue.

This arbitrator, having read both the fee audit prepared by Ms. Comunale on behalf of Respondent and the fee analysis prepared by Ms. Kumar on behalf of Applicant, I conclude that the Comunale Fee Audit is the more credible and persuasive on the question of the allowable rate of reimbursement for the facility fee in connection with the 10/11/24 surgical procedure.

Accordingly, it is my determination that the Respondent having already reimbursed \$794.58 more than the allowable sum of \$3,026.24 has fully reimbursed the Applicant for the facility fee in connection with the 10/11/24 surgery and no additional reimbursement is due.

This decision is in full disposition of all claims for reimbursement of No-Fault benefits presently pending before this arbitrator.

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

08/26/2025
(Dated)

Paul Weidenbaum

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:
ee44bf286f32d9c0702176f1c221bbb1

Electronically Signed

Your name: Paul Weidenbaum
Signed on: 08/26/2025