FORTHRIGHT

In the Matter of the Arbitration between

I.D. individually and Spine & Trauma Institute as assignee

CLAIMANT(s),

v.

Forthright File No: NJ0909001285035
Insurance Claim File No: 50202
Claimant Counsel: Fredson & Statmore, L.L.C.
Claimant Attorney File No: 18280
Respondent Counsel: Dyer & Peterson, P.C.
Respondent Attorney File No:
Accident Date: 04/15/2006

IFA Insurance Co

RESPONDENT(s).

Award of Dispute Resolution Professional

Dispute Resolution Professional: Nanci G. Stokes Esq.

I, The Dispute Resolution Professional assigned to the above matter, pursuant to the authority granted under the "Automobile Insurance Cost Reduction Act", *N.J.S.A. 39:6A-5, et seq.*, the Administrative Code regulations, *N.J.A.C. 11:3-5 et seq.*, and the *Rules for the Arbitration of No-Fault Disputes in the State of New Jersey* of Forthright, having considered the evidence submitted by the parties, hereby render the following Award:

Hereinafter, the injured person(s) shall be referred to as: I.D.

Hearing Information

☐ An oral hearing was waived by the parties.

☒ An oral hearing was conducted on: 05/30/12.

Claimant or claimant's counsel appeared by telephone. Respondent or respondent's counsel appeared in person.

The following amendments and/or stipulations were made by the parties at the hearing:

The claim is amended to $114,317.32. This matter was initially part of a consolidated case which was deconsolidated due to discovery and other issues. The issues as to pre-certification for the surgery on 3/31/09, proper coding, multiple procedure rule reductions as well as appropriate usual and customary reductions were thoroughly addressed in a prior Award authored by this DRP as to the previously consolidated cases, namely, *Paramus Surgical Center/Bergen Pain Management/Bergen Pain*

Anesthesia a/s/o ID v. IFA Ins., NJ1245221 (National Arb. Forum, January 22, 2011). Claimant and respondent stipulate that the prior Award's determination as to these issues appropriately applies based upon principles of collateral estoppel and issue preclusion under the circumstances of the cases. Medical necessity was not disputed in the prior matter and is similarly not disputed here. Further, respondent acknowledges that an appeal had been supplied (as noted and accepted in the prior Award) disputing the denial of medical necessity of the surgery and that respondent had an opportunity to address same such that an appeal issue need not be decided in this matter. Thus, this Award largely addresses whether reimbursement of codes billed only by this provider are permitted and at what reimbursement and/or usual and customary rate as well as follow up treatment. The findings of the prior Award are set forth in this matter where appropriate for clarification. It is noted that the medical records of this claimant were reviewed in the prior case involving this patient and surgery.

Findings of Fact and Conclusions of Law

Nature of Dispute:

I. Are additional codes billed by this claimant (as the primary surgeon without the use of an assistant surgeon) permitted reimbursement? What reimbursement is owed?

The following documentation was submitted for consideration:

Claimant:
Demand including: bills and assignment.
Submission dated 4/1/10 with EOBs, medical records, and coding materials.
Submission dated 7/2/10 including: certification.
Letter dated 5/29/12 with attachments
Certification of Services.

Respondent:
Submission dated 5/10/12 including: letter memorandum and DPRP as well as submissions from the prior cases dated 10/21/09 with medical records and IMEs, 10/23/09 with coding audit and EOBs, 10/06/10 with bills and Awards as well as a letter memorandum with Bulletin 10-30, coding materials and other documents.

I also heard the arguments of counsel.

I. The prior Award noted that certain codes were not on the pre-certification request for surgical services and as such, a penalty was applied to CPT codes 22632, 22852, 20930, 20937, A4649 and C1781 and is similarly applied in this case. Additional services at issue only in this case are similarly not on the pre-certification request: CPT codes 20926, 38220, 17999, 27299, 20930 and L0631. These services would also be subject to a 50% penalty having not been included in the request for treatment authorization.

The respondent supplied a surgeon coding expert as to the inclusion of several codes in other procedures per a review of the operative report, in particular, 63056 and 63057 would be considered as included in the codes CPT 22630 and 22632. It is noted that no modifiers were used and there was no medical explanation as to why the codes would not be considered included. Other services were considered included by the expert and are addressed below.

Further, it was determined per the evidence and coding audit, that CPT codes 22612, 22614, 22851, 22851-59, 22842, 38220, 20930, 20926, 20937, and 17999 would be properly reduced by the multiple reduction formula (if awarded) applicable to multiple procedures ("MPRF") performed in the same body region, e.g., back. It is noted that CPT 27299 was a pelvic procedure and is not considered the same region as the back per the MPRF.

The primary procedure would be the fusion per the surgeon coding expert. Thus, CPT 22630 and CPT 22632 would be paid at 100%. In this regard, respondent clarifies that the "each additional level" code CPT code 22614 is joined with CPT 22612. Thus, both would be paid at 50% as a secondary procedure.

This acknowledges the add-on designation to this procedure. CPT 22612 would carry modifier-51. This was accepted by this DRP.

The following rates were determined adequate for the following codes in the prior Award:

CPT 22630: $12,000
CPT 22632: $3,000
CPT 22612: $12,000
CPT 22614: $3,000
CPT 22842: $3,500
CPT 22851: $4,000
CPT 20937: $1,459.96

Thus, Spine and Trauma is owed the following for these codes as the primary surgeon (reductions determined in the prior Award):

$12,000 for CPT 22630
$1,500 for CPT 22632 (at 50% per the penalty, not subject to MPRF).
$6,000 for CPT 22612 ((MPRF at 50%)
$1,500 for CPT 22614 (MPRF at 50%)
$437.50 for CPT 22842 (MPRF at 25% and the pre-certification penalty).
$1,000 for CPT 22851 (MPRF at 25%)
$1,000 for CPT 22851-59 (MPRF at 25%)
$364.99 for CPT 20937 (MPRF at 25% and the pre-certification penalty).

The following additional codes were billed by the claimant:

CPT 38220 (billed $1,000 x3), Bone marrow aspiration.
CPT 20926 (billed $2,000), Tissue Graft
CPT 17999 (billed $2,000), unlisted procedure, skin and subcutaneous tissue
CPT 27299 (billed $2,000), unlisted procedure, pelvis or hip joint
CPT 20930 ($1,002) Allograft
CPT 76000 ($1,500), fluoroscopy
CPT 76001($1,500), fluoroscopy (assisting physician)
L0631($300) lumbar orthotic, rigid

The respondent utilizes the Medicare/CMS system in processing the surgery as well as AMA materials and the surgeon coding audit. Many of the AMA positions are adopted by the NCCI edits in CMS. NCCI edits are coding methodologies created by the Centers for Medicare and Medicaid Services (CMS) to instill correct coding guidelines as to coding combinations reported on claims with CPT and HCPCS Level II codes. Certain codes are not paid separately when billed with other codes except under certain circumstances. These guidelines are incorporated to the New Jersey regulations addressing coding/billing.

N.J.A.C. 11:3-29.4(g), as in effect for the services in question, states that "artificially separating or partitioning what is inherently one total procedure into subparts that are integral to the whole for the purpose of increasing medical fees is prohibited. Such practice is commonly referred to as "unbundling" or "fragmented" "billing". Providers and payors shall use the National Correct Coding Initiative Edits, incorporated herein by reference as updated quarterly by CMS and available at http/:www.cms.hhs.kov/NationalCorrectCodIniEed/."

Certain coding edits are found in a column format. One first looks to the Column 1 code (referred Comprehensive) and then to Column 2 (referred Component) NCCI column edits, to decide whether CPT and/or HCPCS codes billed/coded together by the same physician for the same patient on the same date of service are eligible for separate reimbursement. Each NCCI edit has an assigned indicator (meaning the last column or column 3) that decides whether the various codes may be reimbursed separately when provided on the same date.

Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to by-pass an NCCI edit if the clinical circumstances do not justify its use.

Within column 3, an indicator of "0" indicates that allowable NCCI-associated modifiers cannot be used to bypass the edit. Thus, it is not possible to obtain reimbursement for both codes billed by the provider on the same date in any circumstance.

An indicator of "1" means that a correctly coded and the use of modifier -59 or other approved modifiers (such as modifier-25) can be used to allow submitted services or procedures. Thus, the provider may be reimbursed for both codes if billed with the modifier and that modifier is supported as appropriate in the records.

An indicator of "9" indicates that the edit has been deleted, and the modifier indicator is not relevant.

Respondent asserts that CPT 38220 is included in 20937 and that fluoroscopy (76000 and 76001) is included in the fusion procedures (22630, 22632 and 22842). No modifiers were used and many coding pairs have "0" indicators (no modifier can be used to avoid the edit). This is supported by the coding audit opinion and NCCI. It is noted that the audit suggest CPT 27299, 17999 and 20926 are adequately included in other services billed. However, a review of the operative report notes the complexity and extensive nature of the bone and tissue grafting involved. As to the pelvic procedure specifically, a careful review of the operative report notes that the bone marrow was taken from the pelvic region to be used as a bone graft and following the removal of bone marrow the pelvis was "reconstructed with back filler." As such, I find that the services are supported by my review of the operative report. The NCCI edits as to inclusion do not support the audit's position as to CPT 20926. Thus, I find that the provider is not owed reimbursement as to CPT codes 38220, 76000 and 76001, but may bill CPT codes 27299, 17999 and 20926. It also would appear that Dr. Ragukonis would have been the correct provider to bill but CPT 76001 even if not included.

Further, while other procedures were to the back and subject to the multiple procedure reduction formula, the pelvic region is not considered the back (CPT 27299). Thus, I find this service is paid at 100% of the appropriate usual and customary rate

In addition, L0631 is considered inappropriately billed by respondent in that there is no documentation to support billing of the code. The lumbar brace is not discussed in any record nor is there an indication that the orthotic was, in fact, supplied to the patient. As such, I agree that this code is not adequately supported.

Claimants supply EOBs relative to the codes billed indicating a consistency of its rates charged and reimbursed in this case. Claimants assert they have sustained its burden and are owed the balance of its fees.

Pursuant to N.J.A.C. 11:3-29.4(e), for services not included in the fee schedule, the insurer's limit of liability for any medical expense benefit shall be a reasonable amount considering the fee schedule amount for similar services. Where no similar service is identified on the fee schedule, the insurer's limit of liability shall not exceed the usual, customary and reasonable fee ("UCR") in the region where the services were provided. The fee schedule in effect on the dates of services contains no similar services.

Respondent is required to prepare an analysis of the provider's fee(s) to determine whether the fee is usual, customary and reasonable as compared to other providers in the same geographic area "based on its experience." 24 N.J.R.1348. Respondent supplies Wasserman data to support rates to be paid in this case. Awards and exemplar bills are also in evidence.

The Fee Schedule and regulations addressing the determination of usual, customary and reasonable rates were revised. The revisions were to become effective 10/1/07, but that date was stayed by Court order. In the case of *In Re Adoption of N.J.A.C. 11:3-29 by the State of N.J., Dep't of Banking & Ins.*, 410 N.J. Super. 6, 48-55 (App. Div. 2009), the Appellate Division ratified the amendments to the regulation establishing an effective date of 8/10/09 for the revised fee schedules. Although the revisions were not in effect on the date of service in question, respondent argues that the decision highlights the incorrect manner in which DRPs determined such cases. Further, the newly ratified regulations established a more detailed methodology to determine UCR and permits use of national databases. The date of service pre-dates the effective date of the revisions but post dates the drafting of the revisions. Ingenix was enjoined from use until the Department was able to review the credibility of the database based on concerns as to the possibility that Ingenix skewed its results to suggest a reduction in fee reimbursement.

The Department's Order A10-113 noted its analysis and favorable determination as to the use of Ingenix. That Order noted that the Appellate Division accepted its use of the rates paid by automobile insurers in its fee schedule analysis. *In re Adoption*, supra, at 38-39.

The Department's Bulletin Number 09-26 followed the Appellate Division's decision and advised that "the new rules and fee schedules will apply to bills for services or supplies provided on or after August 10, 2009 and the prior rules and fee schedules will apply to bills for services or supplies provided prior to that date."

In upholding the regulations and fee schedules, the Appellate Division noted the following:

> The proposed rule conforms to Cobi. Under N.J.A.C. 11:3- 29.4(e) (1), the provider submits his or her usual and customary fee. The insurer then determines the reasonableness of the fee. That is no different than the procedure in Cobi. The new provision allows the insurer to consult with a national database for help in determining the reasonableness of the fee. Such a procedure will provide more protection against arbitrary determinations to the providers. Nevertheless, if a provider disagrees with the insurer's determination, the provider has the option of filing for arbitration. N.J.S.A. 39:6A-5.1. There is accountability and meaningful review.

In re Adoption, supra.

Thus, the Appellate Division essentially affirmed Cobi but made clear that it is the insurer's responsibility to assess reasonableness and agreed that databases may be used in that process. Further, the Court considered the newly ratified Fee Schedule as "reasonable" given that the Department had made "considered and informed judgments" in developing its rules and comprehensive fee schedules. However, the Court also noted that it was not "an exact science."

In *Cobo v. Mkt Transition Facility*, 293 N.J. Super. 374 (App. Div. 1996), the Court addressed UCR determinations and this case is considered the seminal case on that issue. The Court noted that the plaintiff medical provider's revision of its fees to increase billing rates to the permitted fee schedule rates was inappropriate. The provider had failed to show that its billing was usual and customary despite its apprarent reasonableness and congruity with the new Fee Schedule. Thus, it was not an issue as to reasonablness of the actual fees charged, but rather a failure as to the initial part of the UCR analysis. The *Cobo* court also identified factors to be utilized in determining UCR, including: (1) the fees charged by other providers for the subject service, (2) the provider's billing history, and (3) any disparity in billing submitted to different insurance carriers. *Id.* at 387. As the Court noted, the Department of Banking and Insurance advised that "the provider, in submitting the billings, makes the initial determination of as to his/her usual and customary fee." 24 N.J.R. 1348. The determination as to reasonableness then flow to the insurer.

The Department recently issued a Bulletin relative to the UCR determinations being made in the arbitration system. Bulletin Number 10-30 advises that:

> Many DRPs incorrectly assert that UCR fees can be demonstrated by simply reviewing examples of provider invoices. The DRPs who do so frequently rely upon language from *Cobo v. Mkt. Transition Facility*, 293 N.J. Super. 374 (App. Div. 1996) as the authority for this position. This is legally incorrect and ignores the fact that through amendments to the PIP Medical Fee Schedule rule adopted subsequent to *Cobo*, the Department established a different process for how UCR is to be calculated. The Department's rule at N.J.A.C. 11:3-29.4(e)1 clearly states that the provider is to submit his or her usual and customary fee for the service and it is the insurer, not the provider that is to determine reasonableness. The rule was upheld by the Appellate Division (*In Re Adoption of*

> *N.J.A.C. 11:3-29 by the State of N.J., Dep't of Banking & Ins.*, 410 N.J. Super. 6, 48-55 (App. Div. 2009)), and clearly permits insurers to use national databases to determine the reasonableness of a provider's usual and customary fee. Further, in accordance with the Appellate Division's decision, the Department in Order A10-113 concluded that the Ingenix MDR database can be used by insurers to determine the reasonableness of fees that are not on the fee schedule. Therefore, DRPs should be following this new procedure for determining the appropriate UCR reimbursement.

The revised regulation N.J.A.C. 11:3-29.4(e)(1), in part, states that:

> For the purpose of this subchapter, determination of the usual, reasonable and customary fee means that the provider submits to the insurer his or her usual and customary fee. The insurer determines the reasonableness of the provider's fee by comparison of its experience with that provider and with other providers in the region. The insurer may use national databases of fees, such as those published by Ingenix (www.ingenixonline.com) or Wasserman (http://www.medfees.com/), for example, to determine the reasonableness of fees for the provider's geographic region or zip code.

It is clear that the newly ratified fee schedule and regulations cannot be applied retroactively. However, it is noted that the Appellate Division's decision concluded that the regulations essentially followed *Cobo*, supra, as previously relied upon to determine UCR. The Bulletin only clarifies the Department's position on the manner in which UCR should be addressed and should have been addressed under *Cobo*. The code revision eliminates any possible misapplication of the Court's holding in *Cobo*. The Appellate Division, however, did not preclude the ability of a provider to challenge a carrier's determination of a reasonable fee even where a database is used.

Claimants note that the Appellate Division opted to make the fee schedule regulation and schedule revisions prospective as of the date of its decision, but could have made the revisions retrospective to the initial effective date.

Based on the weight of the evidence, I find claimant has sustained its burden as to the codes at issue but for CPT 20930 which I find should have a usual and customary rate of $800. The provider's proofs indicate inconsistent billing of this code within a short period of time and that the rate previously billed is in line with respondent's Wasserman value as to this code. All other codes not previously determined are adequately supported by claimant's exemplars and Awards.

Thus, the following is owed for codes billed only by this provider and deemed appropriate for reimbursement:

CPT 20926: $250 (MPRF at 25% and the pre-certification penalty).
CPT 17999: $250 (MPRF at 25% and the pre-certification penalty).
CPT 27299: $1000 (pre-certification penalty, but no MPRF).
CPT 20930: $100 (MPRF at 25% and the pre-certification penalty).

X-rays on 5/6/09 and 6/11/09 ($62.27 each)

Follow up on 7/22/09 at $27.53.

As such, the total owed to this claimant is $25,554.56.

It is noted that balance billing of the patient is prohibited.

I find that the claimant to be a prevailing party and I award attorney's fees and costs. An award of attorney's fees to a successful claimant is not mandatory but lies within the sound discretion of the Arbitrator as provided for under N.J.A.C. 11:3-5.6(b)(3). In determining the proper amount of fees, "the most useful starting point . . . is the number of hours reasonably expended on the litigation multiplied by a reasonable hourly rate." *H.I.P. v. K. Hovnanian at Mahwah VI, Inc.*, 291 N.J. Super. 144, 157 (App. Div. 1996). Depending on the evaluation of factors set forth in R.P.C. 1.5, the fact finder is given discretion to adjust the fees upward or downward in its discretion. *Id.* at 158, 160. *See Enright v. Lubow*, 215 N.J. Super. 306 (App. Div. 1987); *see also Scullion v. State Farm Ins. Co.,* 345 N.J. Super. 431, 437-438 (App. Div. 2001).

Having reviewed the Certification of Services submitted by claimant and considered the opposition of respondent; I award $1,600 in fees and $231 in filing fees and service costs. This represents a reduction in the hourly rate and hours billed based on respondent's arguments. The fees awarded are in conformity with guidelines/factors set forth in R.P.C. 1.5. Specifically, consideration has been given, but not limited to, the novelty and difficulty of the questions involved, the skill requisite to perform the legal services properly, the fees customarily charged in the locality for similar legal services, the amount involved and the results obtained, as well as the experience, reputation and ability of the lawyer performing the service. Claimant's counsel has considerable experience in this area. Three providers were involved. Numerous dates of care and significant amounts were involved. A detailed submission was prepared. Considerable documentation was reviewed and compared. Based on the result obtained, issues involved and preparation in this matter, the fees are appropriate.

Interest is mandatory on overdue claims. N.J.S.A. 39:6A-5(h). Respondent is to calculate interest upon payment per its receipt of the bills and statutorily mandated rates.

Therefore, the DRP ORDERS:

Disposition of Claims Submitted

1. Medical Expense Benefits: Awarded:

Medical Provider	Amount Claimed	Amount Awarded	Payable To
Spine & Trauma Institute.	$114,317.32	$25,554.56	Spine & Trauma Institute.

Subject to co-payment, deductible and the policy limits.

2. Income Continuation Benefits: Not in issue.

3. Essential Services Benefits: Not in issue.

4. Death or Funeral Expense Benefits: Not in issue.

5. Interest: I find that the Claimant did prevail. Interest is awarded pursuant to *N.J.S.A. 39:6A-5h.*: Respondent is to calculate interest upon payment per its receipt of the bills and statutorily mandated rates.

Attorney's Fees and Costs

☐ I find that the Claimant did not prevail and I award no costs and fees.

☒ I find that the Claimant prevailed and I award the following costs and fees (payable to Claimant's attorney unless otherwise indicated) pursuant to *N.J.S.A. 39:6A-5.2g:*

Costs: $ 231 Attorney's Fees: $ 1,600

THIS AWARD is rendered in full satisfaction of all claims and issues presented in the arbitration proceeding.

Entered in the State of New Jersey

Nanci G. Stokes, Esq.
Dispute Resolution Professional

Date: 07/14/12