In the Matter of the Arbitration between

Seaview Orthopaedics a/s/o T.S.
CLAIMANT(s),

v.

Forthright File No: NJ1906001846668
Proceeding Type: In-Person
Insurance Claim File No: 0456906247-02
Claimant Counsel: Midlige Richter
Claimant Attorney File No: 350.1664
Respondent Counsel: Chasan Lamparello Mallon & Cappuzzo, PC
Respondent Attorney File No: 21319-0960
Accident Date: 05/15/2017

Allstate New Jersey
RESPONDENT(s).

Award of Dispute Resolution Professional

Dispute Resolution Professional: Andrew A. Patriaco 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: T.S.

In Person Proceeding Information

A proceeding was conducted on: 12/17/2019

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

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

None

Findings of Fact and Conclusions of Law

This is a claim arising out of an accident that occurred on May 15, 2017.

Claimant submitted the following documents:

1) Demand for Arbitration filed on June 6, 2019.

2) Letter dated December 12, 2019 with attachments.

3) Fee certification.

Respondent submitted the following documents:

1) Letter dated August 14, 2019 with attachments.

2) Letter dated August 28, 2019 with attachments.

3) Letter dated December 20, 2019 with attachments.

The amount claimed ($52,739.64) represents an alleged balance due after respondent provided a payment for a surgery on January 22, 2019. Claimant billed $68,360.99 for CPT code 22551. Respondent crosswalked the billed code to CPT codes 63075 and 22554 and paid $15,621.35. Claimant seeks the difference of $52,739.64. Medical necessity is not in issue. The issues to be decided are whether respondent's crosswalking was proper and UCR.

Crosswalking of CPT Code 22551 to CPT Code 22554 and CPT Code 63075

According to the operative report on January 22, 2019, claimant/Doctor Yalamanchili, performed a C7-T1 anterior cervical discectomy, decompression, and fusion, C7-T1 anterior cervical instrumentation, C7-T1 interbody cage application, and local morselized autograft.

According to the AMA CPT Manual, 22551 is described as "arthrodesis, anterior, interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots cervical below C2." CPT code 22554 is "arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than a decompression), cervical below C2. CPT code 63075 is "discectomy, anterior, with decompression of spinal cord and/or nerve roots, including osteophytectomy, cervical, single interspace."

CPT code 22551 is not a fee schedule item. Respondent contends that this code should be crosswalked to similar fee schedule codes 22554 and 63075, pursuant to N.J.A.C. 11:3-29.4(e). Respondent argues that 22554 and 63075 describe similar services as that of 22551. It is respondent's position that 22551 represents an anterior cervical decompression and fusion and that 22554 (fusion) and 63075 (discectomy/ decompression) describe similar services.

Respondent relies upon the report of April Winnies, CPC. It contends that 22551 should be crosswalked to 22554 payable at the fee schedule allowance of $5,961.42 and 63075 payable at the fee schedule allowance of $9,659.93. CPT code 22551 should not be paid on a UCR basis.

Claimant argues that the AMA has assigned a CPT code, 22551, for the surgery performed on January 22, 2019. It points out that the AMA CPT Manual specifically states, "Do not report 22554 in conjunction with 63075, even if performed by a separate individual. To report anterior cervical discectomy and interbody fusion at the same level during the same session, use 22551.

Claimant also offers Doctor Yalamanchilli's appeal to respondent dated August 15, 2019. Doctor Yalamanchilli referenced the above section of the CPT Manual. He also states that CPT code 22551 describes a complete discectomy while 22554 describes a minimal discectomy and 63075 describes a discectomy with decompression. Doctor Yalamanchilli states that CPT code 22551 is the proper code for the surgical procedure performed on January 22, 2019.

I have reviewed the entire submissions of the parties and considered the argument of counsel. I find that CPT codes 63075 and 22554 do not describe a similar service to CPT code 22551 as was performed in this matter. CPT code 22551 includes a fusion, discectomy and decompression of the spinal cord and/or nerve roots. These procedures were performed. CPT code 22554 describes a minimal discectomy, fusion, but not a decompression. CPT code 63075 does not include a fusion as was performed here.

Further, the AMA CPT Manual is clear on this issue as set forth above. I also find the opinions of Doctor Yalamanchilli to be convincing and persuasive. I find that CPT code 22551 describes the procedure performed herein. I find that CPT codes 22554 and 63075 do not describe a similar service. In weighing the evidence on this issue, I find claimant has prevailed by a preponderance of the evidence. Claimant is entitled to payment for CPT code 22551 on a UCR basis.

UCR

CPT code 22551 is not a fee schedule item. Thus, a usual, customary, and reasonable analysis applies. Where the fee schedule does not contain a reference to a similar service, the insurer's limit of liability for any medical expense or service shall not exceed the usual, customary, and reasonable fee. (N.J.A.C. 11:3-29.4[e]).

For the purposes 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 by means of explanations of benefits from payors showing the provider's billed and paid fee(s). 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. National databases of fees, such as those published by FAIR Health or Wasserman for example, are evidence of the reasonableness of fees for the provider's geographic region or ZIP code. The use of national databases of fees is not limited to the above examples. When using a database as evidence of the reasonableness of a fee, the insurer shall identify the database used, the edition date, the geozip, and the percentile.

When conducting a UCR analysis, it is initially the medical provider who determines what his or her usual, customary, and reasonable fee is. "It is incumbent on the insurer, based on its experience with the particular provider or other providers in the region, to determine whether, in fact, the usual, customary and reasonable fee has been billed". Cobo v. Mkt. Transition Facility, 293 N.J. Super. 374, 386 (App. Div. 1996), Citing, response by the Commissioner at 24 N.J.R. 1348 (April 6, 1992). The court identified factors to be utilized in determining the reasonableness of the provider's fee, including: (1) the fees charged by the 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.

Claimant contends that its charge of $68,360.99 was its usual and customary charge and that the charge was reasonable. It offers one EOB on this issue and Optum 360 Fee Analyzer wherein 22551 at the 75th percentile is $69,989.98.

Respondent contends that claimant's charge was not reasonable. It offers data from The Physician's Fee Reference and argues that $10,064.04 represents a reasonable allowance for CPT code 22551.

I have reviewed the entire submissions of the parties and considered the argument of counsel. Based on

the evidence presented and pursuant to Cobo, I find that claimant's charge of $68,360.99 was not reasonable. I find a reasonable charge to be $55,000.00. Respondent paid $15,621.35. Therefore, I award $39,378.65 to claimant. Interest is to be calculated and paid by respondent.

Attorney's Fees and Costs

An award of attorney's fees to a successful claimant is not mandatory, but, per N.J.A.C. 11:3-5.6(e)(1)(2), lies within the discretion of the DRP. In determining an appropriate amount of fees, it has been suggested that "the most useful starting point is the number of hours reasonably expended on the litigation multiplied by reasonable hourly rate." HIP v. K. Hovnanian at Mahwah, 291 N.J. Super. 144,157 (App. Div. 1996). However, per R.P.C. 1.5, the DRP is given discretion to adjust the fees upward or downward. Id. at 158, 160. The Administrative Code also mandates that a calculation for the "lodestar" be completed, "which is the number of hours reasonably expended by the successful claimant's counsel in the arbitration multiplied by the reasonable hourly rate". See, N.J.A.C. 11:3-5.6(e)(1).

In making those adjustments, the trial court (or DRP) should consider the following:

1. The insurer's good faith in refusing to pay the demand;
2. [The] excessiveness of plaintiff's demand;
3. [The] bona fides of one or both of the parties;
4. The insurer's justification in litigating the issues;
5. The insured's conduct in contributing substantially to the necessity [of litigation];
6. The general conduct of the parties;
7. The totality of the circumstances.

See, Scullion vs. State Farm Ins. Co., 345 N.J. Super. 431 (App. Div. 2001) quot., Enright vs. Lubow, 215 N.J. Super 306, 313 (App. Div.) certif. den. 108 N.J. 193 (1987).

The claimant has submitted a certification of services in the amount of $2,827.50. Having considered the respondent's objections and all relevant circumstances, I find that the claimant is entitled to attorney's fees totaling $1,300.00. While this figure reflects a reduction in counsel's hourly rate and the amount of time expended, it comports with the guidance provided by HIP, R.P.C. 1.5, Scullion and Enright and fully and fairly compensates counsel. I also award costs in the amount of $225.00.

Therefore, the DRP ORDERS:

Disposition of Claims Submitted

1. Medical Expense Benefits: Awarded

Medical Provider	Amount Claimed	Amount Awarded	Payable To
Seaview Orthopaedics	$52,739.64	$39,378.65	Seaview Orthopaedics

The awarded amounts are subject to:
Deductibles
Co-payments

2 . Income Continuation Benefits	Not in Issue	
3 . Essential Services Benefits	Not in Issue	
4 . Death Funeral Expense Benefits	Not in Issue	
5 . Award of Interest	Awarded	Amount to be calculated by Respondent pursuant to N.J.S.A. 39:6A-5.2g

Attorney's Fees and Costs

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

Cost:$ 225.00 Attorney's fees:$ 1,300.00

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

Entered in the State of New Jersey

Andrew A. Patriaco, Esq.
Dispute Resolution Professional

Date:02/13/20