IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT – LAW DIVISION

MEDICOS PAIN & SURGICAL SPECIALISTS, S.C., and AMBULATORY SURGICAL CARE FACILITY, LLC **Plaintiffs,**	)	**No. 12 L 4145**
v.	)	Honorable Thomas R. Mulroy
ACUITY INSURANCE COMPANY and BILL'S DRYWALL, INC. **Defendants.**	)	

ORDER

The issue in this trial is whether plaintiffs are entitled to additional payment from defendants as the result of defendant Acuity Insurance Company's pre-approval of a surgical procedure for one of plaintiffs' patients. The court heard the testimony of the witnesses and reviewed the exhibits admitted into evidence. Both sides submitted written closing arguments.

Plaintiffs billed 76% of its surgical cost to the insurance company, which amounted to $73,852.15 and after first refusing to pay any reimbursement, defendant insurance company finally reimbursed plaintiffs $28,935.07. Plaintiffs claim they are due $27,192.56. The parties agree that defendant Acuity pre- approved the surgery at issue on December 15, 2010 and Acuity's adjuster, who issued the pre-approval to plaintiffs, testified that his company rarely, if ever, issues pre- approvals for surgery, but that it did so in this case. The surgery took place on February 1, 2011. The pre-approval

form (Plaintiffs' Exhibit 9) is on Medicos Pain & Surgical Specialist stationary and states:

> We are requesting authorization for the following procedure(s):
> Patient: Garcia, Alejandro DOB: 05/20/76
>
> Claim# NF4323 DOI: 06/16/10
>
> Procedure: Right Shoulder Scope, Subacronial Decompression, Rotator Cuff Repair
>
> Diagnosis: Right Shoulder Rotator Cuff Tear
>
> Date of Surgery: AS SOON AS POSSIBLE. Surgeon: DR. NAM, M.D.
>
> __X_ Approved Approved by: *Mike Neal*
> *Acuity*
>
> _____Denied Date: 12/15/10
>
> *Please provide documentation on your decision for our records.
>
> ***Please be advised that this does not include any additional finding once the procedure is being performed.***

The surgery was performed February 11, 2011 in reliance on Acuity's pre-approval but Acuity refused to pay when the bill was submitted. Plaintiffs then filed an appeal to Acuity and Acuity responded by paying $28,935.07 instead of the $73,852.15 which was billed. In connection with this litigation, Acuity, through its billing review

company, reviewed the bill again and claimed it overpaid plaintiffs by $5,000. In its closing argument defendant said:

Defendants paid ASCF $28,935.07 on December 20, 2011. This amount, which constituted an overpayment, adequately compensated plaintiffs under the Illinois Workers' Compensation Act's Fee Schedule for the services provided." (Closing Argument p. 6)

Defendants argued at trial that plaintiffs failed to prove the existence of an unambiguous promise, reasonable reliance, and a resulting detriment.

The court carefully considered the testimony of the witnesses and carefully analyzed their credibility. The court found Dr. Derrick Wallery extremely credible and believable. His demeanor was calm, he answered all the questions asked to the best of his recollection and he gave direct answers. He responded carefully to questions on cross examination and appeared to be honest and forthright in his answers.

The court found Mike Neal, Acuity claims adjuster's testimony that he pre-approved this surgical procedure to be credible. Other than affirming that he pre-approved the procedure and identifying his signature, he had little direct, independent knowledge of this particular case and added little to the defense in this matter. His testimony was general and did not provide a reason for Acuity to refuse to pay plaintiffs' submitted bill.

Ms. Watson, Corvell's bill review manager's testimony was not credible. The court carefully listened to her and found that her answers were not believable and her demeanor was not consistent with credibility. She tried to assist Acuity but did not have the specific knowledge or credibility to do so. Defendants did not rely on her testimony in their closing argument.

The Court finds in favor of plaintiffs and against defendants in the amount of $27,192.56 plus statutory interest in the amount of $9,554.54.

It is hereby Ordered:

1. The Court finds in favor of plaintiffs and against defendants in the amount of $27,192.56.

2. Plaintiffs are entitled to statutory interest in the amount of $9,554.54.

3. Judgment is entered in favor of plaintiffs in the amount of $36,747.10

Judge Thomas R. Mulroy, Jr.

OCT 18 2013

Circuit Court-1941

_____, 2013

ENTER:

Judge Thomas Mulroy

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IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, LAW DIVISION

MEDICOS PAIN & SURGICAL SPECIALISTS, S.C and AMBULATORY SURGICAL CARE FACILITY, LLC,	)	**No. 2012 L 004143**
Plaintiffs,	)	**Commercial Calendar Q**
v.	)	**Honorable Frank B. Castiglione**
THE HARTFORD FINANCIAL SERVICES GROUP, INC., SPECIALTY RISK SERVICES, LLC, and ARAMARK CORPORATON,	)	
Defendants.	)	

ORDER

This matter comes before the Court on Defendants' The Hartford Financial Services Group, Inc., Specialty Risk Services, LLC and Aramark Corporation ("Defendants"), Motion to Dismiss Plaintiffs' Medicos Pain & Surgical Specialist, S.C. and Ambulatory Surgical Care Facility, LLC ("Plaintiffs") Complaint pursuant to 735 ILCS § 5/2-619; the Court having considered the parties' written submissions in connection with the Motions to Dismiss; the Court being advised of the premises.

Finds:

When proceeding under a 2-619 motion, the movant concedes all well-pleaded facts set forth in the complaint, but does not admit conclusions of law. *Piser v. State Farm Mut. Auto. Ins. Co.*, 405 Ill. App. 3d 341, 346 (1st Dist. 2010). In reviewing the sufficiency of the complaint, the Court accepts as true all well-pleaded facts and all reasonable inferences that may be drawn from those facts. *Porter v. Decatur Mem. Hosp.*, 227 Ill. 2d 343, 352 (Ill. 2008). A section 2-619 motion to dismiss should be granted only when it raises affirmative matter which negates the plaintiff's cause of action completely or refutes critical conclusions of law or conclusion of material, but unsupported fact. *Ferguson v. City of Chicago*, 213 Ill. 2d 94, 96-97 (2004). One of the enumerated grounds for a section 2-619 dismissal is that the claim is barred by affirmative matter which avoids the legal effect of or defeats the claim. 735 ILCS § 5/2-619(a)(9). Affirmative matter is "something in the nature of a defense that negates the cause of action

completely or refutes crucial conclusions of law or conclusions of material fact contained in or inferred from the complaint." *In re Estate of Schlenker*, 209 Ill. 2d 456, 461 (2004); *Illinois Graphics Co. v. Nickum*, 159 Ill. 2d, 469, 486 (1994). Upon ruling on a 2-619 motion, the court must deny the motion if there is a material and genuine question of fact. 735 ILCS § 5/2-619(c); see also, *Semansky v. Rush-Presbyterian-St. Luke's Medical Ctr.*, 208 Ill. App. 3d 377, 384 (1st Dist. 1990).

Plaintiffs performed medical services to Araceli Martinez who was injured during the course of his employment at Aramark. Hartford provides workers' compensation coverage to Aramark. After his injury, Martinez sought compensation under the Illinois Workers' Compensation Act (820 ILCS 305). After visiting Medicos, it was determined that Martinez would require surgery. Medicos sought approval from Defendants and the procedure was approved. The surgery was performed, but Plaintiff has not been paid in full for its services. Plaintiff filed this suit to recover under the doctrine of Promissory Estoppel.

Promissory Estoppel is a doctrine under which a plaintiff may recover without the presence of contract. *Lawrence v. Bd. of Educ. of School Dist.*, 152 Ill.App.3d 187, 201 (5th Dist. 1987). To establish a claim for promissory estoppel, plaintiff must allege and prove that: (1) defendants made an unambiguous promise to plaintiff; (2) plaintiff relied on such promise; (3) plaintiff's reliance was expected and foreseeable by defendants; and (4) plaintiff relied on the promise to its detriment. *Chatham Surgicore, Ltd. v. Health Care Serv. Corp.*, 356 Ill.App.3d 759, 800 (1st Dist. 2005), citing *Quake Constr., Inc. v. Am. Airlines, Inc.*, 141 Ill.2d 281, 309-10 (1990).

Defendant argues that the case should be dismissed because the Illinois Workers' Compensation Commission has exclusive jurisdiction over the issues presented. The Illinois Workers' Compensation Act states that "[w]hen a patient notifies a provider that the treatment, procedure, or service being sought is for a work-related illness or injury and furnishes the provider the name and address of the responsible employer, the provider shall bill the employer directly." 820 ILCS 305/8.2(d). In this case, Plaintiff, the provider, billed Hartford, the employer's insurer, and has not received full payment for its services. The question presented is whether the dispute over non-payment should be before the circuit court or before the Workers' Compensation Commission.

The Illinois Workers' Compensation Act is designed to provide financial protection to workers for accidental injuries arising out of and in the course of employment. *Meerbrey v. Marshall Field & Co.*, 139 Ill. 2d 455, 462 (1990). A dispute between a health care provider and an employer for services rendered is not encompassed within the purpose of the Act and is beyond the Act's scope. *See Roche v. Travelers Property Casualty Insurance Company*, No. 07-cv-302-JPG, 2008 U.S. Dist. LEXIS 57418, at *10-11 (S.D. Ill. July 24, 2008) (applying Illinois law) (stating that health care providers cannot recover damages under the Illinois Workers' Compensation Act and disputes between them and employers are not within the scope of the Act). Attaining compensation for Martinez, which is a proper workers' compensation issue, is collateral to the dispute between his health care provider and his employer.

After accepting as true all well-pled facts of the Plaintiff's Complaint, Defendant's section 2-619 Motion to Dismiss Plaintiffs' Complaint is DENIED.

Wherefore, it is hereby

ORDERED:

1. Defendants' section 2-619 Motions to Dismiss Plaintiff's Complaint is DENIED
2. Defendant has 21 days, until 9-12-12 to answer Plaintiffs complaint.
3. This case is set for further status on 9-13-12 at 9:30 a.m., without further notice.

Entered:

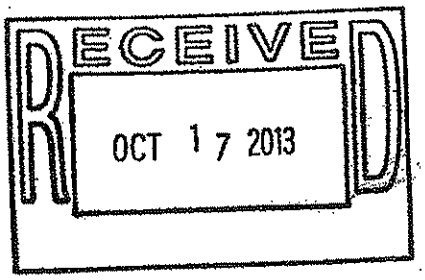
_____

Judge Frank B. Castiglione
Circuit Court of Cook County, Illinois
County Department, Law Division

ENTERED
JUDGE FRANK CASTIGLIONE-1675
AUG 23 2012
DOROTHY BROWN
CLERK OF THE CIRCUIT COURT
OF COOK COUNTY, IL
DEPUTY CLERK

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION



Sonia Avila,

Petitioner,

vs.

NO. 10 WC 416

OSI Industries, LLC,

Respondent.

ORDER

This matter comes before the Commission on Petitioner's Petition for Penalties and Attorneys' Fees. After due consideration, the Commission denies Petitioner's Petition for Penalties and Attorneys' Fees for the reasons set forth below.

1. Petitioner filed an Application for Adjustment of Claim on January 6, 2010 which listed a date of accident of September 24, 2009 and alleged repetitive trauma injuries to her right hand. The claim was assigned to Arbitrator Kane.

2. The parties entered into a lump sum settlement contract. Respondent offered and Petitioner accepted $50,000.00 in full, final and complete settlement of all claims. The amount represented approximately 21.21% of a person as a whole, 50 weeks of TTD, plus $100.00 for other valuable consideration to resolve all disputed issues. Respondent agreed to pay all reasonable and necessary medical bills pursuant to the applicable fee schedules and for medical bills submitted prior to contract approval. The parties expressly waived all rights under §8(a), §16 and §19, including §19(h) of the Act. Arbitrator Kane approved the lump sum settlement contract on November 18, 2011. (CommEx1, Exhibit 1).

3. On October 1, 2012, Petitioner filed this Petition for Penalties and Attorneys' Fees. In his Petition, Petitioner's attorney alleged that Respondent had vexatiously delayed or refused payment of all the medical bills that had been submitted prior to contract approval. Petitioner's attorney alleged that prior to the settlement of the case, he had forwarded all the medical bills to Respondent, including the medical bills at issue and subject to this petition. In a letter dated May 10, 2011, Petitioner's attorney tendered copies of unpaid bills to Respondent's attorney and demanded they be processed for payment. (CommEx1, Exhibit 2). In a letter dated July 15, 2011, Petitioner's attorney sent an additional demand for payment of unpaid medical bills to Respondent's attorney. (CommEx1, Exhibit 3). On September 7, 2011, Petitioner's attorney sent to Respondent's attorney a letter and CD tendering complete copies of all records and the outstanding bills and again demanded they be processed for payment. (CommEx1, Exhibit 4).

Subsequent to contract approval, on December 23, 2011, Petitioner's attorney again demanded payment of the medical bills and advised Respondent's attorney that unless payment was issued, a Petition for Penalties and Attorneys' Fees would be filed. He acknowledged receipt of the settlement check. Petitioner's attorney noted that his office had requested that the settlement include the medical expenses for him to resolve and pay, but Respondent refused and insisted on paying the medical bills directly to the providers. Petitioner's attorney noted that at the time the case was settled, he submitted a fee schedule analysis with the bills from Marque Medicos including statutory interest and from Medicos Pain & Surgical Specialists including statutory interest. Petitioner's attorney requested that Respondent's attorney or the adjuster contact the medical providers and pay or resolve the medical bills. (CommEx1, Exhibit 5).

In his Petition, Petitioner's attorney alleged that Respondent has refused to pay or satisfy the reasonable and necessary medical bills of Marque Medicos for $3,417.54 and of Medicos Pain & Surgical Specialists for $3,587.39. Petitioner's attorney also requested statutory interest of 1% per month for payments not made within 60 days of the submission of the medical bills and necessary claim forms and medical records, pursuant to §8.2(d) of the Act. Petitioner's attorney requested penalties under §19(l) and §19(k) and attorneys' fees under §16 of the Act. The Petition for Penalties and Attorneys' Fees was set to be heard by Commissioner Basurto on October 29, 2012. On that date, the matter was continued to December 19, 2012. On that date, the matter was continued to January 30, 2013. On that date, the matter was continued to April 24, 2013.

4. Hearing on the matter was held on April 24, 2013 before Commissioner Basurto. At this hearing, Petitioner's witness Randall Pace testified that he is licensed attorney in Illinois and Director of Revenue Generation for Premier Billing Solutions, Inc., who oversees all the coding, billing and collection activities on behalf of Marque Medicos and Medicos Pain & Surgical Specialists (Tr 8-9). Premier Billing Solutions submits claims timely with proper supporting documentation and he monitors payment activity to determine whether claims were paid properly and in accordance with the medical fee schedule and appeals any claims that are not paid and calculates interest due pursuant to §8.2(d) of the Act (Tr 9). Mr. Pace testified that he became familiar with the account of patient Sonia Avila (Tr 10). He identified Px2 as the Health Insurance Claim Form for Marque Medicos for date of service February 12, 2010, billed February 15, 2010. Px2 noted charges of $76.00 under CPT code 97032 and $388.00 under CPT code 97110 (Tr 11). Mr. Pace testified that the above CPT codes pertain to physical therapy services performed on February 12, 2010 (Tr 11). Mr. Pace then identified Px3 as a fee schedule and interest statement he prepared pertaining to the above CPT codes on April 22, 2013 (Tr 12). Px3 indicates that for CPT code 97032 the amount due as per the IWCC Fee Schedule is $71.61 and for CPT code 97110 is $268.88, a total of $341.49. Interest was calculated beginning on April 20, 2010, 64 days from the date the bill was mailed February 15, 2010. The interest for CPT code 97032 is $25.85 and for CPT code 97110 is $97.43 based on 36.09942136 months, total accrued interest of $123.28. The total amount due is $464.77 ($341.49 + $123.28). Mr. Pace testified to the above figures on Px3 and that no payment had been received by Respondent (Tr 13-16). He submitted Px2 to Respondent's insurer at least 5 times (Tr 17). Mr. Pace recalled that he emailed the adjuster and attached claim forms and records indicating that the charges were outstanding (Tr 17). Px2 and Px3 were admitted into evidence (Tr 18-19).

Mr. Pace identified Px4 as a UVO4 claim form for Medicos Pain & Surgical Specialists for services rendered on April 20, 2010 (Tr 20). Px4 noted charges of $12,817.31 under CPT code 2539059 described as radius or ulna osteoplasty and $14,599.87 under CPT code 29846 described as surgical arthroscopy of the wrist. Another UVO4 claim form is stamped with the words "Reconsideration Facility Charges" and noted charges of $12,817.31 under CPT code 25390 described as radius or ulna osteoplasty and was created on December 28, 2011. Px4 also contained an Operative Report by Dr. Wiesman dated April 20, 2010 which noted a pre-operative diagnosis of 1) right TFC tear and 2) ulnar impaction. Dr. Wiesman performed 1) right wrist arthroscopy with synovectomy and debridement, central portion TFC and 2) right ulnar shortening using the Rayhack System. A copy of an x-ray film of Petitioner's right forearm was attached to the Operative Report. Mr. Pace testified that the initial bill for the two procedures was sent to Respondent's insurer on April 28, 2010 (Tr 22). Mr. Pace testified that Premier Billing Solutions, Inc., received full payment pursuant to the fee schedule for CPT code 29846 (Tr 22). Mr. Pace then identified Px5 as a fee schedule and interest statement he prepared pertaining to the CPT code 25390 on April 22, 2013 (Tr 22). This was for the ulnar shortening procedure done on April 20, 2010 (Tr 23). The billed amount was $12,817.31. The amount due pursuant to the fee schedule is $7,174.78. Interest was calculated beginning on July 1, 2010, 64 days from the date the bill was mailed April 28, 2010. Mr. Pace testified and Px5 shows that Medicos Pain & Surgical Specialists received payment of $3,587.39 on October 7, 2010, 50% of the amount due pursuant to the fee schedule ($7,174.78 X 50% = $3,587.39) (Tr 23-24). The amount due as per the IWCC Fee Schedule is $3,587.39. The number of months interest had accrued prior to partial payment was listed as 15.22225145 and the amount accrued prior to partial payment was listed as $1,092.16. The number of months interest had accrued after partial payment was listed as 18.5099474 and the amount accrued after partial payment was listed as $664.03. The total accrued interest is $1,756.19 ($1,092.16 + $664.03). The total amount due $5,343.58 ($3,587.39 + $1,756.19). Mr. Pace testified to the above figures on Px4 and Px5 (Tr 24-27). Px4 and Px5 were admitted into evidence (Tr 28-29).

On cross-examination, Mr. Pace testified that part of his duties include helping to generate revenue on behalf of Premier Billing Solutions, Inc. (Tr 30). He has dealt with Petitioner's attorney before, speaking with him once or twice a month (Tr 30). Premier Billing Solutions, Inc., is a separate company from Marque Medicos and Medicos Pain & Surgical Specialists (Tr 31). Premier Billing Solutions, Inc., handles accounts for Marque Medicos, Medicos Pain & Surgical Specialists and Ambulatory Surgical Care Facility, all interrelated companies (Tr 31-32). He believed that those companies refer clients to Petitioner's attorney (Tr 32). Mr. Pace has his license to practice law and also handles cases on behalf of Premier Billing Solutions, Inc., pertaining to cases in claims involving patients treated by Marque Medicos, Medicos Pain & Surgical Specialists and Ambulatory Surgical Care Facility (Tr 32). The fee schedule figures he used were from the IWCC website, which he uses all the time (Tr 33). The 1% interest figure is from §8.2(d) of the Act (Tr 33). CorVel did explain their position to him regarding Px5, but not Px3 (Tr 34). Mr. Pace is familiar with the "59 modifier" (Tr 34). He is not a physician and is not a certified professional coder (Tr 34-35). He was not present when the surgery was performed (Tr 35). It is his understanding that the 59 modifier is appended to a CPT code to notify a payer that the code is a separate, distinct procedure that was performed at a different anatomical site and also potentially different incision being made to

perform that code and it is to signify that the CPT code is not subject to a multiple procedure reduction (Tr 36).

The 59 modifier reduction was applied to the initial UVO4 claim form in Px4, which noted CPT code 2539059 (Tr 38). Premier Billing Solutions, Inc., requested that the reduction be reconsidered, noted on the other UVO4 claim form which is stamped with the words "Reconsideration Facility Charges" under CPT code 25390 (Tr 38). It was his understanding that the reduction was being based upon the assertion by CorVel that the multiple procedure rule should be applied to the date of service April 20, 2010, therefore paying the first code in full and then reducing the second code by 50% and he was advised of such (Tr 38). In connection with that reduction, an appeal letter was submitted by the appeals department of Premier Billing Solutions, Inc., along with the claim form for reconsideration (Tr 38-39). Nataliya Kurchiy, a certified coder employed by Premier Billing Solutions, Inc., generated the appeal letter (Tr 40). He is not seeking payment of CPT code 97010 on Px2, the charges for hot and cold packs (Tr 42).

Petitioner's witness Nataliya Kurchiy testified that she is a certified professional medical coder and biller (Tr 46). She identified Px6 as her curriculum vitae (Tr 47). After completing her bachelor's degree in business administration, Ms. Kurchiy attended a 17 course program which provided comprehensive training in outpatient and inpatient billing and coding as well as medical terminology, anatomy and physiology, introduction to coding, ICD9 coding, CPT coding and electronic medical records (Tr 48-49). Her education and work experience were listed on Px6 (Tr 48). She is a member of the nationally recognized American Academy of Professional Coders, which required her to take an examination (Tr 49-50). She became a Certified Professional Coder in December 2010 (Tr 51). In April 2012, she passed an additional examination and obtained a Certified Professional Coder Hospital for facility billing (Tr 51-52). She currently works for Premier Billing Solutions as a medical coder and biller, assigning appropriate CPT, ICD9 and HEUBG pick codes (Tr 52). She stays current on coding issues and guidelines to bill properly. She also follows up with insurance carriers after medical bills are submitted regarding payment or denial (Tr 53). If she disagreed with the denial reason, she may draft an appeal letter related to payment reductions based on her coding knowledge and experience (Tr 53-54). She reviews the medical records and bills of Medicos Pain & Surgical Specialists with respect to their outpatient surgery billing and assigns CPT codes applicable to the procedures performed (Tr 54). Px6 was admitted into evidence (Tr 54).

Ms. Kurchiy testified she is familiar with the CPT codes of the American Medical Association (Tr 56). She was shown Px4 and identified it as a UBO4 form, a claim form that is used for facility billing of services (Tr 56). She reviewed the Operative Report with attached copy of x-ray film of Petitioner's right forearm (Tr 57-58). Ms. Kurchiy recited the procedures listed on the Operative Report (Tr 59). Over Respondent's objection, Ms. Kurchiy testified that the arthroscopy was performed on Petitioner's right wrist and that the ulnar shortening was performed on Petitioner's right forearm (Tr 61-62). Ms. Kurchiy was shown Px11a, an anatomical chart of the forearm. Over Respondent's objection, Ms. Kurchiy testified that Px11a accurately showed evidence of the location of an incision for an ulnar shortening (Tr 67-68). Ms. Kurchiy was shown Px11b, an anatomical chart of the wrist. Over Respondent's objection, Ms. Kurchiy testified that Px11b accurately showed the site of an incision for an arthroscopic

TFC repair (Tr 68). Over Respondent's objection, Px11a and Px11b were admitted into evidence (Tr 68-69). Ms. Kurchiy then recited the Operative Report itself (Tr 71-73). The ulnar shortening was an open procedure according to the Operative Report (Tr 73). In terms of her responsibility as a coder, Ms. Kurchiy testified that these were two separate and distinct procedures that she would normally bill and code separately (Tr 78).

Ms. Kurchiy identified Px9a as a page copied from Appendix A of the Care and Procedural Terminology Book where there is a list of full modifiers and description defined by the American Medical Association (Tr 78-79). She testified that the statement regarding the rule 59 modifier in Px9a is an accurate statement and was in effect in 2010 when the services were rendered to Petitioner (Tr 80). Ms. Kurchiy testified that from a professional coding standpoint, the rule 59 modifier is applicable to the surgical charges of Medicos Pain & Surgical Specialists that are referenced in Px4 (Tr 80). Px9a is from the AMA 2006 CPT coding book (Tr 81). Px9a was admitted into evidence (Tr 81). In pertinent part Px9a states, "59 Distinct Procedural Services: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, 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 physician. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used." Ms. Kurchiy testified that modifier 59 was appropriate in these circumstances because there was a distinct procedure performed, distinct anatomic sites and different incisions involved that the surgeon used (Tr 82).

Ms. Kurchiy was aware that Medicos Pain & Surgical Specialists received 50% of what was billed for the surgery. She drafted an appeal letter based on her coding knowledge and experience and the details described in the Operative Report (Tr 83). In her appeal letter, she explained why Medicos Pain & Surgical Specialists expected to get the full 100% of the fee schedule (Tr 83). Ms. Kurchiy identified Px10 as her November 15, 2012 appeal letter to CorVel (Tr 83-84). In her appeal letter, Px10, Ms. Kurchiy stated that it was appropriate to append the modifier 59 to CPT code 25390, indicating that the procedure or service represented a distinct procedure or service from others billed on the same date of service. She indicated that the first procedure (CPT code 29846) was carried out arthroscopically on the right wrist and the second (CPT code 25390-59) was done on the right forearm via open approach. "Therefore, two different anatomic sites, as well as two different approaches were involved during the operative session and both CPT codes should have been paid in full. No multiple procedure rule reduction should be applied, even though both procedures were done on the same DOS." Px10 was admitted into evidence (Tr 87).

Ms. Kurchiy identified Px12 as a copy of the IWCC Medical Fee Schedule Instructions and Guidelines (Tr 89). Px12 was admitted into evidence (Tr 91). Ms. Kurchiy testified that Section 8(f) pertains to modifiers. She testified that Page 17 shows that if CPT code was reported with modifier 59, which was listed in the first column, then the third column gives the

payment policy and it should be reimbursed according to the instruction guidelines as lesser of charge or fee schedule amount and it needs to be documented and documentation of service (Tr 92).

On cross-examination, Ms. Kurchiy testified that she obtained her bachelor's degree in Ukraine, where she was originally from. It was a 4-year program that she completed in 2007 (Tr 93). Mr. Pace is part of one department, but he is not her manager and she does not report to him (Tr 93). She does not have discussions about ways to generate new revenue (Tr 93-94). She is not a surgeon and has never performed surgery (Tr 94). The decision as to what procedure is to be performed on a specific patient is completely up to the doctor (Tr 94). It is her understanding that an arthroscopy of the right wrist and an ulnar shortening were performed during the same surgery session on April 20, 2010 (Tr 94). She was not present at the surgery (Tr 97). As far as she could tell, there was one application of anesthetic (Tr 98). It is not up to her to decide if an ulnar shortening also requires an arthroscopic procedure as well (Tr 100).

Respondent's witness Daniella Watson testified she is employed by CorVel Corporation as a bill review operations manager (Tr 102). She manages analysts, coders and nurses that review bills for workers' compensation (Tr 102). She has been at CorVel for 17 years and has been managing that same department for 14 years (Tr 103). She is familiar with CPT coding and the IWCC fee schedule (Tr 103). Ms. Watson had been provided with billing in connection with services rendered on behalf of Petitioner, specifically services rendered by Marque Medicos (Tr 103). Ms. Watson was shown Px2, the bill from Marque Medicos for physical therapy services provided on February 12, 2010 (Tr 104). She had seen this bill before (Tr 104). The bill reflects total charges of $528.00 and CorVel recommended payment of $341.49 (Tr 105). She was shown Px3 and stated that the fee schedule amount was $341.49, the amount that was recommended to pay (Tr 105). Ms. Watson was shown Px4, the bill from Medicos Pain & Surgical Specialists for services rendered on April 20, 2010 and she had seen this bill before a few different times (Tr 106). She or her company had discussions with Marque Medicos' billing services regarding this bill (Tr 106). She had direct involvement regarding this bill and she personally reviewed the charges that were submitted in connection with decisions as to whether or not there were any applicable reduction percent to fee schedules or proper coding methods (Tr 108). Ms. Watson was shown Px5, which indicates that $12,817.31 was billed for CPT code 2539059. The recommendation was payment of $3,587.39 (Tr 109). Over Petitioner's objection, Ms. Watson testified that the bill was reduced to the Illinois fee schedule amount (Tr 109). Also on Px4 there is CPT code 29846 for the amount billed of $14,599.87, the first procedure. CPT code 25390 is a multiple procedure of 29846 (Tr 111). Multiple procedure is when there is a surgery where different services are performed (Tr 111). In assessing multiple procedures and proper billing techniques, as a coding guideline CorVel follows the National Corrective Coding Initiatives (NCCI), which is what the IWCC Fee Schedule follows (Tr 112). In Px4, there is a 59 written after CPT code 25390, which is called a modifier and is added to the CPT code to give additional information. The 59 modifier means that a distinct and completely separate procedure was done (Tr 113).

Ms. Watson is familiar with the AMA CPT code book (Tr 113). She was shown Px9a and agreed that is shows a description of the 59 code modifier. She is familiar with this description (Tr 114). Over Petitioner's objection, Ms. Watson testified that in her assessment in

reviewing this bill, the 59 code modifier was not the proper modifier to apply to this code (Tr 114). The 51 code modifier should have been used designating a multiple procedure (Tr 116). Over Petitioner's objection, Ms. Watson testified that multiple procedure means that the doctor is already doing surgery and has to do another surface in the same spot (Tr 118). Ms. Watson identified Rx1 as a copy of Appendix A from the 2010 AMA CPT code book (Tr 118). In pertinent part Rx1 states, "51 Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (e.g., vaccines), are performed at the same session by the same provider, the primary producer or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes (see Adendix D)." Ms. Watson testified that the 51 code modifier should have been added to the CPT code 25390 (Tr 119).

On cross-examination, Ms. Watson testified that she knows the Chubb Insurance adjuster on this case, Ms. Hier. CorVel does Chubb Insurance's bill reviews (Tr 120-121). CorVel has no business relationship with Marque Medicos or Medicos Pain & Surgical Specialists (Tr 121). She has been at CorVel for 17 years and the relationship between CorVel and Chubb Insurance preceded her employment (Tr 121). There was never any discussion with Chubb Insurance as to how rule 51 modifier ought to be applied to multiple procedures performed in the same surgery (Tr 122-123). The IWCC medical fee schedule instructions and guidelines incorporates the NCCI standards (Tr 123). Ms. Watson is not certified as a CPT coder (Tr 123). There are people at CorVel who are certified as CPT coders (Tr 123). She supervises 13 people (Tr 124). It is a fair statement that she is a professional manager and is not trained as a professional coder (Tr 124). Ms. Watson could have brought a professional CPT coder to testify, but chose not to (Tr 124-125). She has been aware of this issue of whether or not this second surgical procedure performed during the same surgical session should be paid at 100% or 50% of the fee schedule since it was billed with 59 modifier code in November 2012 (Tr 125). She has no training with respect to human anatomy (Tr 125). Ms. Watson reviewed the Operative Report. The arthroscopic procedure was to the wrist (Tr 126). She felt she did not have the clinical experience to talk about exactly what was done (Tr 127). She has not had the training as a coder to determine what codes are applicable (Tr 127). The procedure not paid in full was the right ulnar shortening using Rayhack system, CPT code 25390, an open procedure to the forearm (Tr 127). Ms. Watson testified that she did not have the clinical or educational experience to testify whether or not these were two separate and distinct procedures (Tr 128).

On re-direct examination, Ms. Watson testified that the assessment of whether or not to apply the 59 code modifier or the 51 code modifier when there are two procedures performed is made by the CPT codes and the AMA coding guidelines describes what service was done and what CPT code to use (Tr 128-129). A coder and a nurse review the bills at CorVel (Tr 129). When the bill was first received, there were no modifiers of the CPT codes 29846 and 25390 (Tr 131). In Px4, there is a 59 code modifier on the end of 25390 (Tr 131). Ms. Watson testified that the 59 code modifier was not appropriate because it was not a separate procedure and a multiple procedure was done (Tr 134-135). The 51 code modifier was applied by CorVel (Tr 137-138).

On re-cross examination, Ms. Watson testified that 59 as a modifier is part of the AMA guidelines and the NCCI standards that the IWCC has adopted (Tr 139). The rule 59 modifier covers a situation where multiple procedures are done during the same session, but it is appropriate to code them and pay both at 100% when they are add on codes (Tr 139). Ms. Watson was shown Px9a and recognized it as a true and accurate copy of Appendix A listing modifier 59 (Tr 140). She could not give a clinical answer whether the incision site was at two separate locations on Petitioner's anatomy (Tr 141). On re-direct examination, Ms. Watson was referred to Px12, the copy of the IWCC fee schedule (Tr 142). On Page 15, referring to the 51 modifier, it is stated, "Append modifier one to the additional service performed. Be sure that it is appended to the procedure code with the lower allowed amount." (Tr 144-146). The procedure code referenced would be 25390 (Tr 146).

Ms. Kurchiy was recalled as a rebuttal witness (Tr 147). Rx1 was admitted into evidence (Tr 147). She was shown Rx1, the AMA modifiers which shows modifier 51 (Tr 148). She works with modifier 51 in an ongoing regular basis as a CPT coder (Tr 148). Ms. Kurchiy based her decision to use modifier 59 and not modifier 51 on the definition of modifier 59 and the guidelines (Tr 149). Her reasoning was based on the Operative Report that noted it was done through different incisions at different sites (Tr 150). On cross-examination, Ms. Kurchiy was shown Px4 and acknowledged that in the initial billing submission, neither one of the CPT codes had the 59 modifier appended (Tr 150). The bill was corrected and submitted as a corrected claim with the 59 modifier (Tr 150-151). Add on codes are those codes for procedures that are always done in conjunction with other procedures (Tr 152). Neither modifier 59 or modifier 51 are add on codes (Tr 152). By CPT guidelines, a modifier 51 cannot apply to add on codes because it is already considered that it is in addition, meaning it is an addition to some other major procedure (Tr 152). Neither modifier 59 or modifier 51 are classified by the CPT book as add on codes and they are stand alone codes (Tr 153).

The hearing was continued until May 22, 2013 to determine if the fee schedule amount of $341.49 for bill Px2 had been previously paid (Tr 153-156). Respondent disputed any interest charges for this bill.

5. Further hearing on the matter was held on May 22, 2013 before Commissioner Basurto. Petitioner's attorney stated that in reviewing the matter, the insurance carrier found that Px2 had not been paid and tendered a check to Marque Medicos for $341.49 on April 25, 2013 (Tr 160). A copy of the check and explanation of benefits was admitted into evidence as Hearing Date 2, Px1(Tr 162). Petitioner's attorney maintained the claim for the interest due on this bill. Respondent's attorney moved to dismiss this matter for lack of subject matter jurisdiction because the parties had agreed in the settlement contract to waive §19 and §16 (Tr 163). The parties were given a briefing schedule. Both parties submitted briefs.

Based on the above, the Commission denies Petitioner's Petition for Penalties and Attorneys' Fees. The Commission does have the power to enter §19(l) awards, as well as §19(k) and §16 attorneys' fees, even after its initial jurisdiction has ended. *Board of Education of City of Chicago v. Industrial Commission*, 351 Ill.128, 130-31, 184 N.E.2d 202, 203-204 (1932); *Krantz v. Industrial Commission*, 289 Ill.App.3d at 447, 449, 681 N.E.2d 1100, 1102 (1997). It has been uniformly held that it is the function of the Commission to determine whether an employer has engaged in unreasonable or vexatious delay and to award penalties thereon. *Krantz*, 289 Ill.App.3d at 449, 681 N.E.2d at 1102; see also *Consolidated Freightways, Inc. v. Industrial Commission*, 136 Ill.App.3d 630, 633, 483 N.E.2d 652, 654 (1985). Therefore, the Commission has jurisdiction to consider this issue.

When a delay in paying compensation has occurred, the employer bears the burden of justifying the delay. *Board of Education of City of Chicago v. Industrial Commission*, 93 Ill.2d 1, 9, 442 N.E.2d 861, 865 (1982); *Smith v. Industrial Commission*, 170 Ill.App.3d 626, 632, 525 N.E.2d 81, 85 (1988). Whether the employer's conduct justifies the imposition of penalties is to be considered in terms of reasonableness and is a factual question for the Commission. *Avon Products, Inc. v. Industrial Commission*, 82 Ill.2d 297, 302, 412 N.E.2d 468, 470 (1980); *Boker v. Industrial Commission*, 141 Ill.App.3d 51, 57, 489 N.E.2d 913, 918 (1986).

The Commission finds that Respondent's delay was not intentional, unreasonable or vexatious. There was a genuine dispute as to the use of which CPT coding modifier was appropriate for the procedures performed on April 20, 2010. Respondent argues that CPT code modifier 51 was appropriate and the 50% reduction applied. Petitioner argues that CPT code modifier 59 was appropriate and the reduction did not apply. The Commission finds the testimony of Nataliya Kurchiy to be more credible than the testimony of Daniella Watson, based on her education and experience in coding. In the Operative Report, the Operative Notes state that after completing the arthroscopy portion of the operation, a 10 cm incision on the ulnar aspect of the distal forearm was made starting 2 cm proximal to the ulnar head through the skin dermis and dissected down through the ulnar aspect of the ulna to expose the ulnar bone. An osteotomy was performed as well as placement of plate and screws. Ms. Kurchiy testified that modifier 59 was appropriate in these circumstances because there was a distinct procedure performed, distinct anatomic sites and different incisions involved that the surgeon used.

The Commission finds that the fee schedule amount of $7,174.78 for the right ulnar shortening using the Rayhack System performed on April 20, 2010 should not be reduced by 50%. Medicos Pain & Surgical Specialists received payment of $3,587.39 on October 7, 2010. The amount due as per the fee schedule is $3,587.39. The Commission orders Respondent to pay Petitioner this amount. Regarding interest, Respondent argues that the settlement contract did not call for the payment of interest under §8.2(d) and that Respondent has no obligation to pay interest under the terms of the contract. The Commission notes that the medical fee schedule of the Act is mandatory and provides that all payments to providers for treatment provided shall be made within 60 days of receipt. Where the employer had substantially all the required data to adjudicate the bill, the unpaid portion shall incur interest at a rate of 1% per month. The Commission finds the testimony and calculations of Randall Pace to be credible. The Commission orders Respondent to pay Marque Medicos interest of $123.28 as calculated by Mr.

Pace in Px3. The Commission orders Respondent to pay Medicos Pain & Surgical Specialists interest of $1,756.19 as calculated by Mr. Pace in Px3.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Penalties and Attorneys' Fees is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $3,587.39 for medical expenses under §8(a) of the Act, subject to the Medical Fee Schedule under §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Marque Medicos the sum of $123.28 for interest under §8.2(d) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Medicos Pain & Surgical Specialists the sum of $1,756.19 for interest under §8.2(d) of the Act.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 1 1 2013
MB/maw
r5/22/13
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Mario Basurto

Michael J. Brennan

David L. Gore