

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Mark S. McMahon MD  
(Applicant)

- and -

State Farm Mutual Automobile Insurance  
Company  
(Respondent)

AAA Case No. 17-16-1027-9763

Applicant's File No. SS-23418

Insurer's Claim File No. 32726897

NAIC No. 25178

**ARBITRATION AWARD**

I, Stacey Charkey, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD**:

Injured Person(s) hereinafter referred to as: Assignor

1. Hearing(s) held on 02/07/2017, 07/06/2017  
Declared closed by the arbitrator on 07/06/2017

Gregory Itingen, Esq. from Samandarov and Associates, P.C. participated in person for the Applicant

Mohammed Rubbani, Esq. from Richard T. Lau & Associates participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 5,813.85**, was NOT AMENDED at the oral hearing.  
Stipulations WERE NOT made by the parties regarding the issues to be determined.
3. Summary of Issues in Dispute

Whether Respondent has established its fee schedule defenses; and, if so, whether Applicant has rebutted same.

4. Findings, Conclusions, and Basis Therefor  
I have reviewed the submissions documents contained in the American Arbitration Association's Electronic Case Folder, said submissions constituting the record in this case. This award is rendered upon the oral arguments of the parties at the arbitration

hearing date and the documentary evidence submitted by the parties. There were no witnesses that testified at the arbitration hearing.

According to the records contained in the ECF, the dispute arises from the underlying automobile accident of September 12, 2015, in which the Assignor purportedly suffered injury to the shoulder. Based upon Applicant's recommendation, the Assignor underwent a shoulder surgery on December 8, 2015. Applicant submitted his bill in the amount of \$5,813.85 for the professional services rendered. Respondent received the claims, partially paid the amount of \$1,878.12 for the surgeon's bill and the amount of \$200.96 for the assistant's bill, and denied the balance of the claims based upon fee schedule defenses. The medical necessity of the surgery is not in dispute in this matter.

Applicant billed the following codes and amounts for the services rendered during the surgery on December 8, 2015:

Surgeon's Bill:

CPT Code 29823 - Arthroscopy, shoulder, surgical, debridement -  
\$1,878.12

CPT Code 29820-51 - Arthroscopy, shoulder, surgical, synovitis -  
\$1,628.47

CPT Code 29805-51 - Arthroscopy, shoulder, diagnostic, synovial biopsy -  
\$948.22

CPT Code 23700-51 - Manipulation under anesthesia - \$739.80

CPT Code 20610-51 - Arthrocentesis, major joint - \$57.26

Assistant's Bill:

CPT Code 29823-83- Arthroscopy, shoulder, surgical, debridement - \$200.96 CPT

Code 29820-83- Arthroscopy, shoulder, surgical, synovectomy - \$174.25

CPT Code 29805-83- Arthroscopy, shoulder synovial biopsy - \$101.44

CPT Code 23700-83- Manipulation under anesthesia - \$79.16

CPT Code 20610-83- Arthrocentesis, major joint - \$6.17

Pursuant to 11 NYCRR 65-4.5(o) (1), the arbitrator shall be the judge of the relevance and materiality of the evidence offered and strict conformity to legal rules of evidence shall not be necessary.

A prima facie case of entitlement to No-Fault compensation is made out by submitting evidence that the prescribed statutory billing form has been mailed and received, and that the defendant failed to either pay or deny the claim within the requisite 30-day period. Westchester Medical Center v. Lincoln General Ins. Co., 60 A.D.3d 1045, 877 N.Y.S.2d 340 (2d Dept. 2009); Westchester Medical Center v. Clarendon National Ins.Co., 57 A.D.3d 659, 868 N.Y.S.2d 759 (2d Dept. 2008); New York and Presbyterian Hosp. v. Allstate Ins. Co., 31 A.D.3d 512, 818 N.Y.S.2d 583 (2d Dept. 2006).

An insurer's denial of claim form indicating the date on which it was received adequately establishes that the claimant sent, and that the defendant received the claim. Ultra Diagnostics Imaging v. Liberty Mutual Ins. Co., 9 Misc.3d 97, 804 N.Y.S.2d 532 (App. Term 9th & 10th Dists. 2005).

After reviewing the evidence contained in the ECF, and based upon the stipulation between the parties, I find that Applicant has submitted sufficient credible evidence to establish a prima facie case of medical necessity for the claim. See, Mary Immaculate Hospital v. Allstate Insurance Co., 5 AD3d 742 (2d Dept. 2004); Amaze Medical Supply Inc. v Eagle Ins. Co., 2 Misc 3d 128[A], 2003 NY Slip Op 51701[U] (App Term, 2d and 11th Jud Dists 2003).

Respondent preserved fee schedule defenses in its denial of the subject claims. However, it is Respondent's burden to come forward with competent evidentiary proof to support its fee schedule defenses. See: Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). See also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co., 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006).

If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of

noncompliance with the appropriate fee schedules cannot be sustained. *See: Continental Medical PC v. Travelers Indemnity Co.*, 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1<sup>st</sup> Dep't, per curiam, 2006). A Respondent may interpose a defense in a timely denial that the claim exceeds the fees permitted by the Workers' Compensation schedules, but Respondent must, at minimum, establish, by evidentiary proof, that the charges exceeded that permitted by law. *Abraham v. Country-Wide Ins. Co.*, 3 Misc.3d 130A, 787 N.Y.S.2d 678, 2004 NY Slip Op 50388U, 2004 N.Y. Misc. LEXIS 544 (App. Term, 2d Dept. 2004).

In support of its defenses, Respondent submits the applicable denials with accompanying explanation of benefits and a fee schedule audit performed by Mercy Acuna, CPC, of Signet Claims Solutions, LLC. The audit is specific to this claim and determines the surgeon and physician assistant fees as billed in accordance with the applicable New York State Workers Compensation Fee Schedule.

Ms. Acuna attests that CPT Code 29823 was billed correctly in the amount of \$1,878.12. Ms. Acuna further attests CPT Code 29823 is the highest allowance and reimbursement is allowable at 100%. The remaining portion of the billed CPT Codes are subject to the Workers Compensation No Fault Fee Schedule Ground Rule 5 (Multiple procedure rule), the rule that states that the appropriate reimbursement should consist of the highest procedure billed at the rate of 100% plus the remaining procedures to be reimbursed at 50%. However, Ms. Acuna attests that CPT Codes 29805, 29820, 23700 and 20610 are not reimbursable.

Regarding CPT Code 29805, Ms. Acuna attests that this is a "separate procedure" code and under the Fee Schedule, this CPT Code cannot be billed with other procedures. In regards to CPT Codes 29805 and 29820, Ms. Acuna attests that according to AMA CPT coding guidelines, "surgical endoscopy/arthroscopy always includes a diagnostic endoscopy/arthroscopy) therefore cannot be reimbursed separately...CPT Code 29820 and 23700 are inclusive or bundled with CPT Code 29823 therefore not separately reimbursable...CPT Code 20610 is not separately reimbursable, per the AMA CPT Assistant December 2007, page 10 issue..."

Additionally, Ms. Acuna states that CPT Code 20610 should not be reported when performed concurrent with another intra-articular procedure ... "...Per the operative report the injection was administered on the same shoulder where the arthroscopy was performed therefore the use of the modifier 59 would be inappropriate..."

With respect to the Assistant's bill, Ms. Acuna attests that under the applicable New York State Workers Compensation Fee Schedule, a physician's assistant will receive 10.7% of the total allowable for the surgical procedures. Ms. Acuna further attests "The

only reimbursable CPT Code is 29823 and the allowable amount is \$200.96, which is 10.7% of \$1,878.12. Therefore, the Applicant was correctly reimbursed by Respondent for the Assistant's bill.

The parties disagree about the appropriate fee schedule amounts for portions of this claim. Applicant billed utilizing multiple CPT codes for this right shoulder arthroscopic surgery. Applicant supported its claim for payment of \$3,421.60 for the services of the surgeon and the physician's assistant ("PA") based upon the Affirmation of Aaron J. Perretta, Esq., CPC, of Samandarov & Associates, P.C. This Affirmation was submitted in opposition to the Affidavit of Ms. Acuna, outlined above upon which Respondent relies.

To the contrary, on behalf of Applicant, Mr. Perretta stated that the fee schedule mandates payment of a total of total of \$3,421.60 for this surgery including CPT code 23700 at \$369.90 for the surgeon and at \$39.57 (10.7%) for the PA; and CPT code 20610 at \$28.63 for the surgeon and at \$3.06 (10.7%) for the PA. He reached this conclusion based on his utilization of the applicable relative value units for each of these codes. Mr. Perretta stated that this Surgery Ground Rule is merely a guide to coding but does not directly address these specific codes, and does not justify denial. He argued further that extrinsic sources, such as the AAOS, may not be used to determine a provider's rate of reimbursement under the fee schedule.

As was aptly noted by arbitrator Ellen Weissman, "With regard to my threshold determination regarding the admissibility of Applicant's coder's report of Mr. Perretta, I find that the weight afforded to his Affirmation will be diminished as his bias is inherent based on his dual roles as expert and counsel for Applicant. It would be impossible for Mr. Perretta to provide objective documentary or testimonial evidence having acknowledged that he is associated with the law firm which has been engaged by Applicant to advocate on its behalf. The ethical rules which govern litigation are not relaxed in the arbitration forum. No doubt a Judge would disallow testimony from an expert employed by Applicant's counsel and therefore, this blurred line diminishes his credibility as an expert witness. Since he is ethically bound to zealously represent the interests of this Applicant, he cannot provide a credible objective expert opinion." I must agree with Arbitrator Weissman's opinion with respect to the weight afforded an affidavit of a purported expert witness who is also counsel to the Applicant. While Mr. Perretta is no doubt a credible attorney and may very well be an expert in the field of coding, he is nonetheless the attorney for this Applicant. This duality affects his credibility as a witness.

Moreover, I have reviewed Ms. Acuna's credentials, which are listed at the top of her audit, and find that she is qualified as an expert to render an expert opinion with respect to the applicable Workers Compensation Fee Schedule and the subject medical billing. Essentially the question becomes one of fact and an interpretation of the fee schedules.

I find that based upon the fee schedule audit of Ms. Acuna, Respondent has established its prime facie burden by presenting competent evidentiary proof in establishing its fee schedule defenses. I am not persuaded by Mr. Perretta's affidavit for the reasons outlined above. Accordingly, the claim is denied.

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 New York  
SS :  
County of Queens

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

08/07/2017  
(Dated)

Stacey Charkey

**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:**  
3bf8cada846136211ade593e0c0378b5

### **Electronically Signed**

Your name: Stacey Charkey  
Signed on: 08/07/2017