

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Laxmidhar Diwan MD
(Applicant)

- and -

State Farm Fire & Casualty Company
(Respondent)

AAA Case No. 17-18-1099-9413

Applicant's File No. None

Insurer's Claim File No. 32-9Z24-371

NAIC No. 25143

ARBITRATION AWARD

I, Gary Peters, 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 05/14/2019
Declared closed by the arbitrator on 05/14/2019

Robin Grunert from Jakubowitz Law Firm PC participated in person for the Applicant

Yilo Kang from Freiberg, Peck & Kang, LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 3,165.30**, 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

The Assignor was a 36 year old female who was involved in a motor vehicle accident on 3/25/17. Applicant is seeking reimbursement for a left knee arthroscopic surgery wherein the Respondent made partial payment and denied the balance on the basis of improper billing.

4. Findings, Conclusions, and Basis Therefor

This hearing was conducted using the Electronic Case Folder maintained by the American Arbitration Association. All documents contained in that folder are made part of the record of the hearing and I have reviewed the documents contained therein. Any documents submitted after the hearing or at the hearing that have not been entered in the Electronic Case Folder as of the date of this award, will be listed immediately below this language and forwarded to the American Arbitration Association at the time this award is issued for inclusion.

As stated above, the Assignor was a 36 year old female who was involved in a motor vehicle accident on 3/25/17 and sustained multiple bodily injuries. Particularly in dispute are the Applicant's claims for reimbursement for a left knee arthroscopic surgical intervention as stated above wherein the claim was partially denied based upon a fee schedule dispute.

A review of Respondent's denial of claim (NF-10) indicated that a bill in the sum of \$8,170.61 was received on 6/20/17 and that Respondent made partial payment and the Applicant is seeking the balance of \$3,165.30.

The Respondent provided an affidavit from Carolyn Mallory wherein she reviewed the Applicant's invoice. She is a Certified Professional Coder credentialed with The American Academy of Professional Coders (AAPC). The following grid was prepared by the Respondent's expert, Miss Mallory:

Bill #1: 5/19/17 by Laxmidhar Diwan, M.D. a/a/o Latisha Williams

Bill Audit Findings

Line	Date of Service	CPT Code	Submitted Amount	CPT Code Definition	Correct CPT Code	Correct Reimbursemen
1	5/19/17	29870-LT	\$904.70	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)	n/a	\$0
2	5/19/17	29871-LT	\$1,408.25		n/a	\$0

				Arthroscopy, knee, surgical; for infection, lavage and drainage		
3	5/19/17	29876-LT	\$1,878.12	Arthroscopy, knee, surgical; synovectomy, major, two or more compartments (e.g., medial or lateral)	29876	\$939.06
4	5/19/17	29877-LT	\$814.24	Arthroscopy, knee, surgical, debridement/shaving of articular cartilage (chondroplasty)	29877	\$814.24
5	5/19/17	29879-LT	\$889.82	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture	n/a	\$0
6	5/19/17	29881-LT	\$2,013.46	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving)	29881	\$2,013.46
7	5/19/17	20550-LT	\$131.01	Injections; single tendon sheath, or ligament, aponeurosis (e.g., plantar "fascia").	n/a	\$0
8	5/19/17	20550-LT	\$131.01		n/a	\$0

				Injections; single tendon sheath, or ligament, aponeurosis (e.g., plantar "fascia").		
		Total	\$8,170.61		Total	\$3,766.76

TOTAL ALLOWED AMOUNT - \$3,766.76

TOTAL AMOUNT ALREADY REIMBURSED = \$3,395.52

TOTAL AMOUNT OWED - \$371.24

She noted services were performed in Region IV. The conversion factor for surgery is 229.04.

Her CPT code Calculation was as follows:

29870 - \$0

CPT Assistant May, 2001 "As with all arthroscopic procedures in the CPT manual, a diagnostic arthroscopy is considered to be an inclusive component of a surgical arthroscopy and would not be reported separately.

29871 - \$0

There is no documentation of infection, exudate or any fibrinous clots or drains. Drains would be left in for 24 hours - 48 hours. Based on the documentation irrigation of the joint was performed at the end of surgery which is normal and standard care.

29876 - RVU = 8.20 229.04x8.20 = \$1,878.13 then divide by 2 per ground rule #5 = \$949.06

29877 - RVU = 7.11 229.04 x 7.11 = \$1,628.47 then divide by 2 per ground rule #5 - \$814.24

29879 - \$0

Additionally, there is no documentation of multiple drilling or microfracture. According to The American Academy of Orthopedic Surgeons, "The abrasion arthroplasty or microfracture code (29879) is appropriate when the procedure exposes bleeding subchondral bone". Documentation must support this.

29881 - RVU = 8.79 229.04 x 8.79 = \$2,013.26

20550 x2 - \$0

There is no documentation to support one or two injections into a single tendon sheath, or ligament. An injection was given at the conclusion of surgery into the surgical site but that is not separately reportable and would not be 20550.

Ground Rule #5 - Multiple or Bilateral Procedures

When multiple procedures, unrelated to the major procedure and adding significant time or complexity are provided at the same operative session, payment is for the procedure with the highest allowance plus half of the lesser procedures.

The provider submitted two separate bills. The first bill received rated at \$3,395.52. The second bill came in with the same CPT codes as first bill but with an additional four CPT codes. These additional codes changed the reimbursement of the first four CPT codes. I have combined both bills together with all the CPT codes performed during the surgery and applied the NYS Worker's Compensation Fee Schedule Ground Rules and CPT coding guidelines.

The Respondent's expert contradicted herself in a second Affidavit and stated that

29877 - \$0

Chondroplasty is a service included in CPT Code 29880/29881 as per the Worker's Compensation Medical Fee Schedule definition, CPT Code 29880/29881 "with meniscectomy (medial and/or lateral including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty) same or separate compartment when performed".

29879 - \$0

There is no documentation of multiple drilling or microfracture. According to The American Academy of Orthopedic Surgeons, "The abrasion arthroplasty or microfracture code (29879) is appropriate when the procedure exposes bleeding subchondral bone". Documentation must support this.

29881 - RVU = \$8.79 229.04 x 8.79 = \$2,013.26.

20550 x 2 = \$0

There is no documentation to support one or two injections into a single tendon sheath, or ligament. An injection was given at the conclusion of surgery into the surgical site but that is not separately reportable and would not be 20550.

Ground Rule #5 - Multiple or bilateral procedures

When multiple procedures, unrelated to the major procedure and adding significant time or complexity are provided at the same operative session, payment is for the procedure with the highest allowance plus half of the lesser procedures.

The provider submitted two separate bills. The first bill received rated at \$3,495.52. The second bill came in with the same CPT codes as first bill but with an additional four CPT codes. These additional codes changed the reimbursement of the first four CPT codes. I have combined both bills together with all the CPT codes performed during the surgery and applied the NYS Worker's Compensation fee schedule ground rules and CPT coding guidelines.

TOTAL BILLED AMOUNT - \$8,170.61

TOTAL ALLOWED AMOUNT = \$2,952.52

TOTAL AMOUNT ALREADY REIMBURSED - \$3,395.52

TOTAL AMOUNT OWED = OVERPAID \$443.00

In response to the Respondent's expert, Dr. Diwan submitted a Rebuttal Letter to the Fee Schedule Issues and took issue with two differing affidavits from Ms. Mallory and that she did not explain the reason for her 2 different opinions

Furthermore, CPT code 29870 was billed for a diagnostic knee arthroscopy. Ms. Mallory asserts in both affidavits that a CPT Assistant said this is inclusive of the operative surgery. I will accept the CPT Assistant in this instance and withdraw this charge.

CPT code 29871 was billed for arthroscopy of the knee with "lavage and drainage" to treat or prevent infection. Lavage means to cleanse, rinse or wash the joint out with fluid. The end of the operative note described how I thoroughly irrigated the joint which was with copious amounts of fluid to clean and to prevent infection. The Fee Schedule of the code does not require drains to be left in for 24-48 hours. This was properly billed at \$1,408.25. Ms. Mallory stated there is a 50% rule, so amount for this charge is \$704.13. The charge had been paid by insurance according to the denial of claim.

CPT code 29876 was for the tricompartmental synovectomy. Ms. Mallory agreed it is to be paid. The carrier paid for the charge, according to the denial of claim.

CPT code 29877 was for chondroplasty to treat the chondral damage to the patella of grade 1. Ms. Mallory asserted that this should be reimbursed at \$814.24 in her first opinion. Therefore, the amount for this charge was \$814.24. It was paid by the insurance company, according to the denial of claim.

CPT code 29879 is reported for abrasion arthroplasty. Abrasion arthroplasty can be used to describe performance of chondroplasty that involves where damaged tissue is removed to the bone. In this instance, the operative note describes a chondroplasty for the medial femoral condyle graded III. The grade III classification meant the traumatic injury caused damage of some of the areas down to the bone. Therefore, this was properly billed as the abrasion arthroplasty since it involved chondroplasty to the exposed bleeding subchondral bone, by definition. The charge that should be paid for this code is \$889.82.

CPT Code 29881 was for the medial and lateral meniscectomy billed at \$2,013.46. Ms. Mallory admitted this code must be paid. It was not, according to the denial of claim. The charge owed for this code is \$2,013.46.

CPT code 20550 was for the injections into the joint billed at \$131.01 x 2. Ms. Mallory said this should have been billed as a different code, but does not identify

the code she is changing the charge to or why this other code is more appropriate. Therefore, the charge(s) for the code that are owed is \$262.02.

The total amount owed that the claim is \$3,165.30 for the outstanding charges for codes 29879, 29881 and 20550. I find that the respondent's expert had two different opinions as to reimbursement and give deference to the treating physician and find that his explanation for the procedures in dispute is credible and award the sum of \$3,165.30.

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 applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Status
	Laxmidhar Diwan MD	05/19/17 - 05/19/17	\$3,165.30	Awarded: \$3,165.30
Total			\$3,165.30	Awarded: \$3,165.30

- B. The insurer shall also compute and pay the applicant interest set forth below. 07/05/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest to be 2% per month simple, not compounded on a pro rata basis using a 30 day month. Respondent shall compute and pay Applicant interest from the day of filing of arbitration to the date of payment of the award.

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below

The insurer shall pay th Applicant an attorney fee in accordance with 11 NYCRR 65-4.6(d) or "As this matter was filed on or after February 4, 2015, this case is subject to the provisions promulgated bt the Departmenet of Financial Services in the Sixth Amendment to 11NYCRR 65-4 (Insurance Regulation 68-D).

Accordingly, the insurer shall pay the the Applicant an attorney fee in accordance with the newly promulgated 11 NYCRR 65-4.6(d). This amendment takes into acccount that the the maximim attorney fee has been raised from \$850.00 to \$1360.00

- D. The respondent shall also pay the applicant forty dollars (\$40) to reimburse the applicant for the fee paid to the Designated Organization, unless the fee was previously returned pursuant to an earlier award.

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York

SS :

County of NAssau

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

06/11/2019
(Dated)

Gary Peters

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:
f3d4b9e1c8b1247d9e93486e7d84aae6

Electronically Signed

Your name: Gary Peters
Signed on: 06/11/2019