

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Herschel Kotkes MD, PC
(Applicant)

- and -

State Farm Fire & Casualty Company
(Respondent)

AAA Case No. 17-18-1114-7860

Applicant's File No. 2189212

Insurer's Claim File No. 32-4467-X18

NAIC No. 25143

ARBITRATION AWARD

I, Nancy S. Linden, 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: KR

1. Hearing(s) held on 07/08/2020
Declared closed by the arbitrator on 07/08/2020

Stacy Mandel Kaplan, Esq. from Israel, Israel & Purdy, LLP (Great Neck) participated by telephone for the Applicant

Ryan Waxon, Esq. from James F. Butler & Associates participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 2,168.52**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant reduced its demand to \$1,108.69 in compliance with the New York Workers' Compensation Fee Schedule, and with its withdrawal with prejudice of its claim for the physician's assistant's bill.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The Assignor, KR, a 21-year old female, was involved in a motor vehicle accident on June 10, 2018. Following the accident, KR sought and received treatment including a lumbar percutaneous discectomy with epidural injection, disc injection, and radiographic

interpretation performed on November 13, 2018. Applicant billed Respondent for surgeon's fees related to the aforementioned services. Thereafter, Respondent partially paid Applicant's claim, denying the balance based upon the New York Workers' Compensation Fee Schedule. The issue presented is whether Respondent properly denied Applicant's bill based upon the fee schedule.

4. Findings, Conclusions, and Basis Therefor

The case was decided based upon the submissions of the parties contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives made at the arbitration hearing. There were no witnesses.

Applicant established its prima facie entitlement to reimbursement for no fault benefits based upon the submission of a properly completed claim form setting forth the amount of the loss sustained and that payment is overdue. Mary Immaculate Hospital v. Allstate Ins. Co., 5 AD 3d 742, (2d Dept. 2004). Westchester Medical Center v. Lincoln General Ins. Co., 60 AD 3d 1045 (2d Dept. 2009). Therefore, the burden now shifts to Respondent to prove its defense.

Respondent must demonstrate by competent evidentiary proof that Applicant's claims were in excess of the appropriate fee schedules, otherwise Respondent's defense of noncompliance with the appropriate fee schedule cannot be sustained. Continental Medical, P.C. v. Travelers Indemnity Co., 11 Misc. 3d.145A (App. Term 1st Dept. 2006).

With respect to the surgeon's services provided on November 13, 2018 as part of the lumbar percutaneous discectomy of KR with epidural injection, disc injection, and radiographic interpretation, Applicant billed \$4,826.77. Thereafter, Respondent paid \$2,963.96, denying the balance based upon the New York Workers' Compensation Fee Schedule. At the hearing, Applicant's counsel amended the original bill for code 72295 to \$960.00 and, as such, with Respondent's payment of \$2,963.96, a balance of \$1,108.69 remains. This amount reflects CPT codes 72295 in the amount of \$960.00 and the balance of code 62287 in the amount of \$148.69 as billed by Applicant for the lumbar discectomy.

Respondent submits the affidavit of certified professional coder Mercy Acuna, RN, BSN in support of its contention that Applicant is not entitled to reimbursement for CPT Code 72295 and the balance of code 62287. Interestingly, however, with respect to code 62287, Ms. Acuna acknowledges that the fee schedule for code 62287 is \$2,601.89. With that concession, as only \$2,453.20 was paid to Applicant, the balance of \$148.69 remains due and owing. As to code 72295, Ms. Acuna contends that no additional monies are due as this code is "not separately reimbursable from CPT code 62287". She cites the CPT Book and the AMA CPT Assistant February 2017 issue in support as it states "do not report 62287 in conjunction with 62267, 62290, 62322, 77003, 77012, 72205, 72295, when performed at the same level". Ms. Acuna then asserts that "the operative report indicates that the procedures were performed on the same level, L3-L4

and L4-L5". This statement is illogical on its face and in light of the operative report itself which clearly sets forth "(CPT 62287) LEVEL(S): 2" FOR "L3/L4, L4/L5".

In response to Ms. Acuna's affidavit, Applicant interposes a rebuttal prepared by Applicant's biller, Mary Beth Perdikos. With respect to code 72295, Ms. Perdikos explains

The description of CPT code 72295 is: 'Discography, radiological supervision and interpretation'. CPT Code 72295 is contained in the Radiology section of the Fee Schedule.

The relative value of code 72295 as per the New York State Workers' Compensation Fee Schedule is 12.11. The Conversion Factor for Radiology in Region IV is \$52.90. After multiplying the relative value by the conversion factor (12.11 x 52.90) the total is \$640.62. As per the Multiple Radiology Ground Rule 3, for two continuous parts, the charge shall be the greater fee plus 50% of the lesser fee. Therefore, the second level would be 50% of \$640.62, \$320.31. Since two levels were billed, Applicant is owed at total of \$960.00 for code 72295.

Ms. Perdikos then goes on discuss Ms. Acuna's reliance on the CPT code book and CPT assistant, arguing that it is not necessary to do so. She opines that

the Workers' Compensation Fee Schedule Introduction and General Guidelines section specifically states, 'Please refer to the CPT book for an explanation of coding rules and regulations *not listed* in this schedule'. (emphasis added) Thus, it is not necessary to look to the CPT book or the CPT Assistant, as the necessary codes and rules are contained within the NYS Workers' Compensation Fee Schedule.

In this case, the Worker's Compensation Fee Schedule, effective June 1, 2012, does not indicate that this code should not be used in conjunction with one another. Rather, it acknowledges that the discography will be performed in conjunction with CPT code 62287. The description of CPT code 62287 is:

Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method using needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with the use of an endoscope, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar. (emphasis added)

Ms. Perdikos then distinguishes code 62287 from "the wording of CPT codes 62292, 62318, and descriptions for other codes in the Fee Schedule", asserting that "the description of CPT code 62287 clearly states that the procedure is performed 'with discography,' not 'including discography'". With this analysis and Ms. Acuna's concession as to the full amount warranted for code 62287, Ms. Perdikos thus concludes that Applicant is due \$1,108.69.

Based on the foregoing, I find Ms. Acuna's affidavit to be insufficient to support Respondent's defense. Indeed, Ms. Perdikos presents a very compelling explanation as to why code 72295 should be billed separately from code 62287.

As such, upon a preponderance of the evidence in the electronic case file and following consideration of the arguments raised at the hearing, I find that Respondent has not established its defense on this record. Applicant's claim is, therefore, granted.

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	Amount Amended	Status
	Herschel Kotkes MD, PC	11/13/18 - 11/13/18	\$2,168.52	\$1,108.69	Awarded: \$1,108.69
Total			\$2,168.52		Awarded: \$1,108.69

- B. The insurer shall also compute and pay the applicant interest set forth below. 12/20/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009).

C. Attorney's Fees

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

Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or the court, subject to a maximum fee of \$850." *Id.* The minimum attorney fee that shall be awarded is \$60. 11 NYCRR §65-4.5(c). However, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR §65-4.6(i). For claims that fall under the Sixth Amendment to the regulation the following shall apply: "If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved disputes, subject to a maximum fee of \$1,360." 11 NYCRR 65-4.6(d)

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

07/26/2020

(Dated)

Nancy S. Linden

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:
9345791dcb77f140ad1b73bcf6264d2a

Electronically Signed

Your name: Nancy S. Linden
Signed on: 07/26/2020