American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

McCulloch Orthopaedic Surgical Services, PLLC DBA NY Sports and Joint Orthopaedic Specialists (Applicant)	AAA Case No.	17-19-1127-4138
	Applicant's File No.	SS-95477
	Insurer's Claim File No.	385697K52
- and -	NAIC No.	25178
State Farm Mutual Automobile Insurance Company (Respondent)		

ARBITRATION AWARD

I, Susan Mandiberg, 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: The EIP

1. Hearing(s) held on 07/29/2020
   Declared closed by the arbitrator on 07/29/2020

   Gregory Intingen, Esq. from Samandarov & Associates, P.C. participated by telephone for the Applicant

   Daniel Fuentes, Esq. from Freiberg, Peck & Kang, LLP participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 5,111.13**, was AMENDED and permitted by the arbitrator at the oral hearing.

   At the time of the Hearing, Applicant's counsel amended the total amount in dispute to the sum of $987.69, which is for CPT Code 2999 for the physician ($889.81) and physician assistant ($97.88), respectively. The other CPT Code(s) billed were withdrawn with prejudice, since Respondent tendered payment per Fee Schedule mandates.

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

3. Summary of Issues in Dispute

The 62-year-old female EIP underwent left knee arthroscopic surgery on 12/3/18 following a motor vehicle accident that took place on 9/6/18. The physician and physician assistant fee billing for such surgery is presently in dispute. Applicant contends that the billed amount was appropriate, which Respondent contests, citing Fee Schedule grounds. There is no issue regarding the medical necessity of the services rendered. The issue to be determined is whether Respondent's partial reimbursement was appropriate per Fee Schedule mandates.

4. Findings, Conclusions, and Basis Therefor

This case was decided after due consideration of the arguments of counsel and after a thorough review of the submissions and the documents contained in the electronic case folder maintained by the American Arbitration Association, which are incorporated by reference herein. This case involves the physician and physician assistant fee billing for left knee arthroscopic surgery that was performed on 12/3/18. The services were renderedfollowing a motor vehicle accident that occurred on 9/6/18. Respondent partially reimbursed Applicant for the instant billing, asserting that the billed amounts were in excess of those permitted per the Workers' Compensation Fee Schedule, which Applicant contests. There is no issue regarding the medical necessity of these services. CPT Code 29999 is the only Code presently in dispute.

Pursuant to 11 NYCRR 65-4 (Regulation 68-D), §65-4.5, an Arbitrator shall be the judge of the relevance and materiality of the evidence offered…The Arbitrator may question any witness or party and independently raise any issue that the Arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations. In addition, Master Arbitrator Peter J. Merani, in the case of Sports Medicine & Orthopedic Rehabilitation a/a/o "I.B." v. Country-Wide Insurance Co., AAA Case No. 17-R-991-14272- 3, stated, in relevant part, that "the Arbitrator below is the trier of facts and must evaluate and weigh the evidence presented at the hearing in arrive at his decision. The Arbitrator, in weighing the evidence, has broad powers and discretion in determining what evidence is relevant and material. The Arbitrator is in the best position to evaluate the evidence and decide on the credibility of the submitted documents".

It is well-settled that a health care provider establishes its prima facie entitlement to judgment as a matter of law by proof that it submitted a claim, setting forth the fact and the amount of the loss sustained, and that payment of No-Fault benefits was overdue. Damadian MRI in Canarsie, PC a/a/o Tyrone Harley v General Assurance Co., 1006 NY Slip Op. 51048U; Supreme Court of NY, App. Term., 2d Dept., June 2, 2006; *See*: Insurance Law §5106 a, Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD3d 742, 774 N.Y.S.2d 564 (2004); Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784

N.Y.S.2d 918 [2003 NY Slip Op 51701U (App. Term, 2nd & 11th Jud Dists.)]. *See also*: 11 NYCRR §65-1.1, Vista Surgical Supplies, Inc. v. Metropolitan Property and Casualty Ins. Co., 2005-1328 K C., 2006 NY Slip Op. 51047U, June 2, 2006.

Respondent has the burden of coming 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, 1st Dept., 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, 2nd Dept. 2004). In addition, an Arbitrator is permitted to take judicial notice of the Worker's Compensation Fee Schedule. Kingsbrook Jewish Medical Center v. Allstate Insurance Company, 61 AD 3d 13 (2nd Dept. 2009); LVOV Acupuncture PC v. Geico Insurance Company, 32 Misc. 3d 144 (A) (App. Term 2nd, 11th and 13th Jud. Dists. 2011). Natural Acupuncture Health PC v. Praetorian Insurance Company, 30 Misc. 3d 132 (A), 2011 NY slip op 50040 (U), (App. Term 1st Dept. 2011).

Respondent must "conclusively demonstrate" the proper fee schedule rate of payment for the services rendered in a "coherent manner." Viviane Etienne Med. Care, P.C. v. Country-Wide Ins. Co., 2013 NY Slip Op. 50199(U) (App. Term, 2nd Dept., 2013) ("Defendant was not entitled to the dismissal . . . because 'defendant failed to conclusively establish its stated defense[ ] that the fees charged exceeded the amounts set forth in the workers' compensation fee schedule[.]'"); Tyorkin v. Garrison Prop. & Cas. Ins. Co., 2016 NY Slip Op. 50846(U) (Civ. Ct., Kings Cty., 2016).

CPT Code 29999 is presently in dispute. for both the physician's and physician assistant's billing, respectively. In support of its partial reimbursement, Respondent has submitted a coder's affidavit, which was reviewed and discussed with counsel at the time of the Hearing. With regard to this Code, in pertinent part, the affidavit sets forth the following:

"CPT code 29999 is a surgery code for "unlisted procedure, arthroscopy" with a Relative Value of "BR" (By Report). Per General Ground Rule 3, procedures that are listed with "BR" in the relative value column represent services that are too variable in the nature of their performance to permit assignment of unit values. Fees for such procedures need to

be specified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc. is to be furnished. The insurer shall review all submitted "BR" unit value to ensure that the relative consistency is maintained. The operative report describes this procedure as coblation arthroplasty in the patellofemoral compartment. The provider's comparison letter identifies CPT code 29879 as the appropriate comparative code for this procedure. The operative report indicates that coblation arthroplasty was performed, but it does not state that it was done down to "bleeding bone." As per the American Academy of Orthopaedic Surgeons Bulletin (Apr 2005), the correct CPT code for this procedure is CPT code 29877 and not 29879. CPT code 29877 for "arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)," has a Relative Value of 7.11. However, chondroplasty is not separately reimbursable as the description for CPT code 29880 indicates that chondroplasty is included in that procedure, whether performed in "same or separate compartment(s)." As such, CPT code 29877 is not separately reimbursable."

While this affidavit does correctly denote the billed Code 29999 as "BR" code, the coder then changes the code to 29879, presumably based upon the American Academy of Orthopaedic Surgeons Bulletin, as stated above. This sole cited source was not submitted into evidence to support the Coder's opinion and analysis that no further reimbursement is due. Applicant contends that Respondent did not meet its burden on its Fee Schedule defense, since the coder's affidavit failed to provide any further explanation in support of his opinion that there should be no reimbursement, other than the AAOS guidelines cited, which was omitted from evidence. Applicant further contends that the cited source of this assertion - i.e. the AAOS Complete Global Service Data for Orthopaedic Surgery 2015 - is an unreliable and inaccurate source to deny reimbursement for this billed code and is not recognized as a valid source in interpreting the Fee Schedule. As an additional matter, Applicant submitted numerous Arbitration Awards in support of this position that this was not a proper standard.

As an additional matter, Applicant's counsel argued that since Code 29999 is a "BR' code, Respondent, if it wished to contest and reduce the billed amount. was required to seek verification, which the Respondent in this case did not do. The Ground Rules contained in the Fee Schedule indicate that a "by report" item represents a service that is too variable in the nature of its performance to permit assignment of a unit value. Such procedures are to be justified by a report. Pertinent information concerning the nature, extent, and need for the procedure or service; the time, the skill, and equipment necessary must be furnished by the provider of the service. However, a provider is not required to furnish the requisite "by report" information. Herein, Applicant did generate a comparison letter vis-à-vis this billing, which was sent to the Respondent in support of the code billed.

It is incumbent upon the insurer to request further verification of such information if it questions a provider's charges. If Respondent was not furnished with information essential to the processing of the claim, it should have issued a verification request. *See*: Bronx Acupuncture Therapy, PC v. Hereford Ins. Co., 54 Misc.3d 135(A), 2017 WL

416732 (Table), 2017 NY Slip Op. 50101(U)(App. Term, 2nd Dept., Jan. 20, 2017). Respondent failed to do so in the instant matter and its denial therefore cannot be sustained.

After careful review of the totality of the credible evidence and for the reasons set forth herein, I find that I concur with the position set forth by the Applicant. As such, I find that the Applicant is entitled to be reimbursed for the balance of the surgeon's and physician assistant's fees for the arthroscopic surgery to the right shoulder in dispute.

Accordingly, Applicant is awarded the total amount of $987.69, as amended at the time of the Hearing, for the unpaid balance for the physician and physician assistant's fees for the left knee surgery performed on 12/3/18.

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
	McCulloch Orthopaedic Surgical Services, PLLC	**12/03/18 - 12/03/18**	**$4,617.12**	**$889.81**	**Awarded: $889.81**
	McCulloch Orthopaedic Surgical Services, PLLC	**12/03/18 - 12/03/18**	**$494.01**	**$97.88**	**Awarded: $97.88**
Total			**$5,111.13**		**Awarded: $987.69**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/02/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Respondent shall pay the Applicant interest computed from the above-noted filing date at a rate of 2% per month, simple, and ending with the date of payment of the award subject to the provisions of 11 NYCRR §65-3.9(e).

C. Attorney's Fees

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

The insurer shall also pay the Applicant an attorney's fee based upon the amount awarded herein and the interest, as calculated in section "B" above, and in accordance with the applicable Regulations.

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

07/30/2020
(Dated)

Susan Mandiberg

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:
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Electronically Signed

Your name: Susan Mandiberg
Signed on: 07/30/2020