American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Metropolitan Medical and Surgical, P.C. (Applicant)	AAA Case No.	17-19-1124-2382
	Applicant's File No.	00034881
- and -	Insurer's Claim File No.	32-5610-R44
	NAIC No.	25178
State Farm Mutual Automobile Insurance Company (Respondent)		

ARBITRATION AWARD

I, Mitchell Lustig, 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 11/23/2020
   Declared closed by the arbitrator on 11/23/2020

   Rachel Drachman, Esq. from Drachman Katz, LLP participated in person for the Applicant

   Morgan Beirne, Esq. from Freiberg, Peck & Kang, LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 414.41**, 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 the Respondent properly reduced the Applicant's bills in accordance with the fee schedule?

4. Findings, Conclusions, and Basis Therefor

   In dispute is Applicant Metropolitan Medical and Surgical, PC's claim as the assignee of a 37-year-old female injured in a motor vehicle accident on September 3, 2018, for

reimbursement in the sum of $414.41 for the following services performed for the period of October 9, 2018 to November 5, 2018: (1) an office visit and drug screen testing performed by Igor Zilberman, NP on October 9, 2018: (1) bilateral medial branch nerve block injections and trigger point injections performed by Dr. Cristy Perdue on November 5, 2018.

The Applicant's claim represents the difference between the amount of its bills ($1,165.96) and the amount reimbursed by the Respondent ($751.55).

The Respondent partially denied the claim based upon the grounds that the Applicant billed in excess of the fee schedule.

I have reviewed the documents contained in the ADR Center. This decision is based upon the submissions of the parties and the arguments made by the parties at the hearing.

A heath care provider establishes its prima facie entitlement to No-Fault benefits as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and that payment of No-Fault benefits were overdue. Westchester Medical Center v. Lincoln General Insurance Company, 60 A.D.3d 1045, 877 N.Y.S.2d 340 (2nd Dept. 2009); Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that the Applicant has established a prima facie case.

WHETHER THE INSURER HAS PROVEN THAT THE APPLICANT'S BILLS WERE IN EXCESS OF THE FEE SCHEDULE

An insurance carrier's timely asserted defense that the bills submitted were not properly no-fault rated or that the fees charged were in excess of the Workers' Compensation Fee Schedule is sufficient, if proven, to justify a reduction in payment or denial of claim. New York Hosp. Med. Ctr. Of Queens v. Country-Wide Insurance Company, 295 A.D.2d 583, 744 N.Y.S.2d 201 (2nd Dept. 2002); East Coast Acupuncture, P.C. v. New York Central Mutual Insurance, 18 Misc.3d 139(A), 2008 N.Y. Slip Op. 50344(U) (App. Term 2nd and 11th Jud. Dists. 2008); A.B. Medical Services, PLLC v. American Transit Insurance Company, 15 Misc.3d 132(A), 2007 N.Y. Slip Op. 50680(U) (App. Term 2nd and 11th Jud. Dists. 2007).

The insurer has the burden of coming forward with competent evidentiary proof to support its fee schedule reduction or denial. See, e.g., Roberts Physical Therapy, P.C. v. State Farm Mutual Automobile Insurance Company, 13 Misc.3d 172, 3006 N.Y. Slip Op. 26240 (N.Y. Civ. Ct. Kings Co. 2006).

In the absence of such proof, a defense of noncompliance with the appropriate fee schedule cannot be sustained. Continental Medical, P.C. v. Travelers Indemnity Company, 11Misc,3d 145(A), 2006 N.Y. Slip Op. 50841(U) (App. Term 1st Dept. 2006).

I am permitted to take judicial notice of the Workers' Compensation Fee Schedule. See Kingsbrook Jewish Medical Center v. Allstate Insurance Company, 61 A.D.3d 13, 20 (2nd Dept. 2009); LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), 2011 N.Y. Slip Op. 51721(U) (App. Term 2nd, 11th and 13th Nudists. 2011); Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A), 2011 N.Y. Slip Op. 50040(U) (App. Term 1st Dept. 2011).

In support of its fee schedule defense, the Respondent submitted a Fee Affidavit by its Certified Professional Coder, Beth Seidman, sworn to on February 25, 2020. In her Fee Affidavit. Ms. Seidman asserted that the proper fee schedule rate under the New York State Fee Schedule for the services performed by the Applicant herein is $702.19, not the sum of $1,165.96 billed by the Applicant.

In the within matter, the Applicant billed the following CPT Codes for the office visit and the drug screen testing performed on October 9, 2018: CPT Codes 99205 and 80100. The Applicant billed $200.68 for CPT Code 99205 and the Applicant billed $387.12 for CPT Code 80100.

In her Fee Affidavit, Ms. Seidman down coded the office visit from CPT Code 99205 to 99204 and only allowed payment in the sum of $148.69. With regard to the drug screen testing, Ms. Seidman noted that CPT Code 80100 "has been coded in error" and she only allowed the sum of $35.19 instead of the sum of $387.12 billed by the Applicant.

As specifically noted by Ms. Seidman in her Fee Affidavit:

"The provider has coded CPT code 99205 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity.) in error. An Audit tool was used to formulate the current correct Evaluation and Management CPT code utilizing AMA E&M 1995 guidelines.

The provider has documented; A comprehensive exam.; Complete History and Medical decision making of moderate complexity. The correct CPT code is 99204(Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; **Medical decision making of moderate complexity. As per Clinical Examples of New CPT Codes for Evaluation and Management (E/M) Services (Spring 1992). CPT® Assistant.**

Spring 1992 page 13. 99205 Examples

Initial office evaluation of a 65-year-old female with exertional chest pain, Intermittent claudication, syncope and a murmur of aortic stenosis.

(Cardiology) Initial outpatient evaluation of a 69-year-old male with severe chronic obstructive pulmonary disease, congestive heart failure, anti-hypertension. (Family Medicine)

Initial office visit for a 73-year-old male with an unexplained 20-pound weight loss. (Hematology/Oncology) Initial o?ce visit for a 24-year-old homosexual male who has a fever, a cough, and shortness of breath. (Infectious Disease)

Initial office evaluation, patient with systemic lupus erythematosus, fever, seizures and profound thrombocytopenia. (Rheumatology)

Initial office evaluation and management of patient with systemic vasculitis and compromised circulation to the limbs. **These examples are Medical decision making of high complexity, which the provider has not documented**

CPT code 99204 according to the Official New York Workers' Compensation Medical Fee Schedule, Evaluation and Management Fee Schedule has a total allowable of $148.60 based on the geographic location of the services rendered. Reimbursement was calculated by the following formula: Evaluation and Management conversion factor 10.99 X relative value unit 13.53= $148.69.

CPT code 80100 has been coded in error. The New York Workers Compensation fee schedule will be utilized. CPT code 80104 will replace CPT code 80100. CPT code 80104 according to the Official New York Workers' Compensation Medical Fee Schedule, Pathology and Laboratory Fee Schedule has a total allowable of $35.19 based on the geographic location of services rendered. Reimbursement was calculated by the following formula: conversion factor Pathology and Laboratory $1.19 X relative value units 29.57 = $35.19.

Per the AMA CPT Assistant December 2010 page 7 issue:

Pathology and Laboratory Changes in CPT 2011

For CPT® 2011, significant changes were made specific to the reporting of pathology and laboratory services. This article highlights the subsections within the CPT codebook affected by the changes, including the codes that were moved from the Pathology and Laboratory section to the Digestive System subsection."

Because the "Official New York Workers' Compensation Medical Fee Schedule … directs users to 'refer to the CPT book for an explanation of coding rules and regulations not listed in his schedule,'" and the "CPT book, in turn, expressly makes reference to CPT Assistant," an arbitrator's "refus(al) to consider CPT Assistant" "is incorrect as a matter of law." Matter of Global Liberty Ins. Co. v. McMahon, 172 A.D.3d 500 (1st Dept. 2019).

With regard to the bilateral medial nerve block injections and trigger point injections performed on November 5, 2018, Ms. Seidman asserted that the correct fee under the New York State Workers' Compensation Fee Schedule is $518.61, not the sum of $578.16 billed by the Applicant.

In her Fee Affidavit, Ms. Seidman allowed full reimbursement for the all the CPT Codes billed by the Applicant with the exception of CPT Code 20553. Whereas the Applicant billed $119.10 for the latter CPT Code, Ms. Seidman applied the multiple procedure rule contained in Surgery Ground Rule 5 which provides that "{w}hen 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,"** and only allowed payment in the sum of $59.55, which represented 50 percent of the amount billed.

I find that Ms. Seidman's Fee Affidavit is credbile and persuavie.

I note that the Applicant has **no**t submitted a fee audit or any other expert proof to rebut Ms. Seidman's Fee Affidavit.

After careful review of both parties' evidence, I find that Respondent has established through the fee schedule audit of its expert fee coder that the fees the Applicant charged for the services in dispute herein exceeded the fees set forth in the applicable fee schedule, and that Applicant has failed to refute the insurer's interpretation of the fee schedule. See Natural Acupuncture Health, P.C. v. Praetorian Ins.Co., 30 Misc.3d 132(A), 2011 N.Y. Slip Op. 50040 (U) (App. Term 1st Dept. 2011): Cornell Medical, P.C. v. Mercury Casualty Co., 24 Misc.3d 58, 2009 N.Y. Slip Op. 29228 (App. Term 2nd, 11th and 13th Jud. Dists. 2009). Since the Respondent has already reimbursed the Applicant in the amount of $751.55, which is more than the amount of $702.19 allowed under Ms. Seidman's Fee Affiavit, I find that the Applicant is not entitled to any additional reimbursement.

Accordingly, the Respondent's denials are upheld and the Applicant's claim is denied in its entirety.

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 Nassau

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

11/26/2020
(Dated)

Mitchell Lustig

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:
3cdd79fabbf34bfe12b12851c699cfbc

Electronically Signed

Your name: Mitchell Lustig
Signed on: 11/26/2020