

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Manalapan Surgery Center
(Applicant)

- and -

State Farm Mutual Automobile Insurance
Company
(Respondent)

AAA Case No. 17-19-1147-8632

Applicant's File No. SS-131503

Insurer's Claim File No. 35-6260-D50

NAIC No. 25178

ARBITRATION AWARD

I, Tali Philipson, 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 04/05/2021
Declared closed by the arbitrator on 04/05/2021

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

Joseph J. Licata, Esq. from Rossillo & Licata LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,472.45**, 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 KG, a 43-year-old female, was injured in an automobile accident on December 7, 2018. In dispute are the Applicant's claims for the facility fees associated with a left shoulder arthroscopy and nerve block injection under ultrasound guidance provided to the Assignor on March 22, 2019.

Respondent issued a partial payment denying the balance on the ground that the amount billed exceeded the allowable amount pursuant to the Workers' Compensation Fee Schedule.

4. Findings, Conclusions, and Basis Therefor

The case was decided on the submissions of the Parties as contained in the electronic file maintained by the American Arbitration Association and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in the electronic file for both parties and make my decision in reliance thereon.

A review of the competent evidence in the record reveals that Applicant established a prima facie case of entitlement to reimbursement of its claim, by submitting evidence that the prescribed statutory billing form was mailed and received, and that the Respondent failed to either pay or deny the claim within the requisite 30-day period. Mary Immaculate Hospital v. Allstate Insurance Co., 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004).

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 an Applicant's claims were in excess of the appropriate fee schedules, Respondent'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 Dep't, per curiam, 2006).

Applicant billed \$5,971.14 for the following CPT Codes:

29881 \$3,026.24

29876-59 \$1,472.45

29999-59 \$1,472.45

Respondent reimbursed Applicant \$4,498.69 as follows:

29881 \$3,026.24

29876-59 \$1,472.45

29999-59 \$0.00

Respondent relied upon the affidavit of Certified Professional Coder, Antionette Perrie, DC, Lac, CPC. Ms. Perrie set forth an analysis of CPT Code 29999 pursuant to both the New Jersey and the New York fee schedules and reached that same conclusion, that CPT Code 29999 was not reimbursable as billed here. Her analysis is as follows:

- **Provider billed CPT code 29999-59 in the amount of \$1472.45.** This code is specific for Unlisted procedure, arthroscopy. The operation report indicates that the meniscus was removed from the lateral compartment. A chondroplasty was performed. The chondroplasty is included in the meniscectomy. The surgeon then took a radiofrequency wand to smooth the edges of the chondroplasty. An arthroplasty must be down to the bleeding bone according to definition. (See attached.) Because a wand was used to smooth out the chondral surface does not support billing for an additional procedure, nor does it qualify as an additional procedure. The only instance in which you would use code 29999 for coblation would be as a standalone code when the entire arthroscopy procedure was performed via coblation. This was not the case. With that being said, according to the EAPG, code 29999 is always a level 37 procedure. Therefore, this point is moot. The modifier of -59 is incorrect and the procedure is related to the other two procedures, that is to say, same knee, same session, same injury, same incision. The service consolidates. There is not additional reimbursement.

Applicant relied upon the affidavit of Certified Professional Coder, Aaron J. Peretta who argued that Ms. Perrie offered no proof she possessed the requisite expertise in surgical procedures to competently claim a chondroplasty procedure is always included in a meniscectomy procedure.

After careful consideration of the competing affidavits, I find for the Applicant. I am not persuaded that Ms. Perrie does not possess the requisite expertise; however, I find that there is no support for her conclusion that the chondroplasty is included in the meniscectomy. Ms. Perrie annexed an AAPC Coder Orthopedic Coding Alert which sets forth a hypothetical regarding billing meniscectomy and chondroplasty together. In the hypothetical, a meniscectomy was performed with an abrasion chondroplasty. The recommended payable codes were 29881 for the meniscectomy and 29877-59 for the chondroplasty. Ms. Perrie further highlighter the following section:

Notice the physician doesn't mention an abrasion chondroplasty being down to bleeding bone. The orthopedist is only debriding the chondral surface. So you should not report 29879 (Arthroscopy, knee, surgical; abrasion arthroplasty [includes chondroplasty where necessary] or multiple drilling or microfracture).

Although Ms. Perrie highlighted that section, the prior section assigned a reimbursable CPT Code to the chondroplasty. As such, I am not persuaded that the chondroplasty

merits no reimbursement. Moreover, rather than citing to a specific guideline or ground rule, Ms. Perrie is relying upon a hypothetical which may or may not be comparable to the surgery performed here. I find Ms. Perrie's reliance upon this hypothetical confusing and insufficient to prove that the chondroplasty was not reimbursable. Applicant is entitled to payment of \$1,472.45.

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
	Manalapan Surgery Center	06/12/19 - 06/12/19	\$1,472.45	Awarded: \$1,472.45
Total			\$1,472.45	Awarded: \$1,472.45

B. The insurer shall also compute and pay the applicant interest set forth below. 11/12/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from November 12, 2019 (the date Applicant filed its AR1 with AAA) until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty day month.

C. Attorney's Fees

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

After calculating the sum total of the first-party benefits awarded in this arbitration plus the interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20% of that sum total, subject to a maximum fee of \$1,360. See, 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, Tali Philipson, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

04/17/2021
(Dated)

Tali Philipson

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:
6f8a23e7fe38f9eec0fb19788ced7a16

Electronically Signed

Your name: Tali Philipson
Signed on: 04/17/2021