

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Advanced Orthopaedics PLLC  
(Applicant)

- and -

State Farm Mutual Automobile Insurance  
Company  
(Respondent)

AAA Case No. 17-20-1177-7958

Applicant's File No. 21/685

Insurer's Claim File No. 32-B901-5V4

NAIC No. 25178

**ARBITRATION AWARD**

I, Pamela Hirschhorn, 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: Injured Person

1. Hearing(s) held on 04/30/2021  
Declared closed by the arbitrator on 04/30/2021

Alan Elis, Esq. from Law Offices of Jonathan B. Seplowe, P.C. participated for the Applicant

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

2. The amount claimed in the Arbitration Request, **\$ 2,007.06**, was AMENDED and permitted by the arbitrator at the oral hearing.

\$1,117.24.

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

3. Summary of Issues in Dispute

The injured person was a 56-year-old female involved in the subject motor vehicle accident of October 23, 2019. The claim for the surgeon's services as well as the physician assistant's services in connection with right knee

surgery performed on January 27, 2020, was partially reimbursed based upon a fee schedule defense and the balance was denied. The issue to be decided is whether respondent established its fee schedule defense.

#### 4. Findings, Conclusions, and Basis Therefor

The injured person was a 56-year-old female involved in the subject accident of October 23, 2019. The claim for the surgeon's services in connection with right knee surgery performed on January 27, 2020, as well as the physician assistant's fee in connection with those services were billed in the amount of \$6,602.22, and respondent issued partial reimbursement in the amount of \$4,595.16, leaving a disputed balance of \$2,007.06. At the time of hearing, applicant's counsel amended the amount in dispute to \$1,117.24.

Respondent submitted a fee audit by Antoinette Perrie, D.C., LAc, CPC., who noted that the within provider is a Medical Doctor and that the location of service was in New York, NY. Thus, Dr. Perrie acknowledged that for billing purposes Region IV conversion factors apply and that the conversion factor for surgery in region IV is \$229.04. Dr. Perrie stated that in order to calculate the correct reimbursement according to the NY fee schedule, the relative value of the procedure must be obtained in the NY WC Medical Fee Schedule, Surgery section. The relative value or RVU is multiplied by the surgery conversion factor in region IV. 50% reductions are taken for qualified multiple procedures. Dr. Perrie stated that as per the New York State Workers' Compensation Medical Fee Schedule, Introduction and General Guidelines, Section 11C (3), the physician assistant at surgery will receive 10.7% of the total allowance for the surgical procedures. Payment is made to the employer (the physician). This is reiterated in Surgery Ground Rule 12 F. A modifier of -83 indicates the PA services at surgery. Dr. Perrie noted that the provider billed CPT Code 29880 RT in the amount of \$2,471.34, for right knee *Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed*. Dr. Perrie stated that in order to calculate the correct reimbursement, you must multiply the Relative Value

of the procedure by the conversion factor for region IV. Dr. Perrie stated that this service is considered to be the primary procedure and has the largest reimbursement. Dr. Perrie noted that the RVU is 10.79 and that this value is multiplied by the conversion factor of \$229.04 to arrive at the correct payment. Taking the above rule into consideration, Dr. Perrie found that the correct reimbursement according to the Surgery Fee Schedule is  $\text{RVU } 10.79 \times \$229.04 \text{ (conversion factor)} = \$2471.34$ , and thus the provider was properly paid in the amount of \$2471.34, according to the NY fee schedule. Dr. Perrie also noted that the provider billed Code 29876-51 RT, in the amount of \$939.06. Dr. Perrie found that this code is significant for *Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (e.g., medial or lateral)*, and that the modifier applied in this case is -51 indicating an additional procedure, same knee. Dr. Perrie stated that according to Surgery Guideline 5, additional procedures are reimbursed at 50%. According to the NY fee schedule, the RVU for this procedure is 8.20. Dr. Perrie stated that the operative report indicated that a synovectomy was performed in the medial and patellofemoral compartments to address the generic diagnosis of "extensive synovitis," and that the synovial tissue was removed by shaver. Dr. Perrie stated that the removal of synovial tissue would be inclusive to the other procedures performed and reimbursed in the same compartments, the medial meniscectomy and chondroplasty in the patellofemoral compartment, which is included in 29880. Therefore, Dr. Perrie found that there is no reimbursement. Dr. Perrie also noted that another issue regarding this code is related to the diagnosis. Dr. Perrie stated that extensive synovitis is not an appropriate diagnosis to allow the use of this code as this Code would only be considered to be appropriate in the presence of a pathological situation such as is seen in rheumatoid arthritis or pigmented villonodular synovitis. Dr. Perrie stated that pathology reports must be supplied to confirm pathological diagnosis. Dr. Perrie stated that if the diagnosis was appropriate to support the use of this code and no other procedures had been performed in those compartments, the correct reimbursement would be at 50% of the submitted charge of \$1878.13 which is \$939.07. Dr. Perrie stated that the provider was "generously compensated" for this procedure by the carrier without benefit of a pathology report that justifies the use of the code and also paid in addition to procedures in the same compartments that exclude the use of the code. Dr. Perrie stated that according to the revised CPT®/AAOS guidelines effective January 2013, you can only report 29876 (*Arthroscopy, knee, surgical; synovectomy, major, two or more compartments [e.g., medial or lateral]*) when the document establishes medical necessity of synovial pathology, not just cleaning up loose

synovium that might be fibrillating the joint. Dr. Perrie stated that since the provider had not provided any documentation of synovial pathology that would support reporting 29876, the provider should not have reported that code. Dr. Perrie also noted that the provider billed CPT code 29874 59 RT in the amount of \$860.04. Dr. Perrie stated that this code is significant for Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation). Dr. Perrie stated that according to the CPT, this code should not be reported with other knee arthroscopy codes (29866-29889) and that this code may be reported with a modifier of -59 if the service is performed in a different compartment of the same knee (a compartment where no other procedures are performed). Dr. Perrie stated that the loose body was removed from the patellofemoral compartment according to the body of the operative report. Dr. Perrie stated that a review of the operative report indicated that the synovectomy CPT 29876 was performed in the same compartment for which the surgeon was paid and thus the surgeon should not have been paid for CPT 29874 according to the basic CPT rules if the synovectomy in the same compartment is paid. Therefore, Dr. Perrie stated that the modifier of -59 is supported only by the AAOS and not the CPT. Dr. Perrie stated that the AAOS is the only agency that advocates reporting code 29874 in addition to other codes in the same compartment when the loose body is over 5mm. Dr. Perrie stated that The Introduction and General Guidelines clearly state that the services are listed by Current Procedural Terminology (CPT) codes. These codes are a trademark of the AMA. Dr. Perrie stated that the AMA states that separate reporting for code 29874 is only when in a separate compartment or separate incision. Dr. Perrie stated that the synovectomy was performed in the same compartment and that the chondroplasty was performed in the same compartment. Therefore, Dr. Perrie stated that according to the AMA/CPT there is no separate reimbursement for the service. Dr. Perrie stated that the AAOS guidelines will allow for reimbursement for the procedure in the same compartment if the loose body is over 5mm but that this recommendation does not override the AMA CPT. Dr. Perrie stated that the carrier has "generously accepted" the AAOS Guidelines in this case and provided reimbursement for this procedure, as well as for the synovectomy. Dr. Perrie stated that the reason the code exists is to allow for reimbursement when a surgeon has to enter a compartment to remove a loose body when no other reimbursable procedure will take place in that compartment and that the procedure has an RVU of 7.51. Dr. Perrie stated that taking the above rules into consideration, the correct reimbursement allowing the AAOS guidelines to be applied would be 7.51 RVU x \$229.04 conversion factor = \$1720.09.

Payment at 50% equals \$860.04. Thus, Dr. Perrie found that the provider was paid according to the fee schedule. Dr. Perrie also found that the chondroplasty was performed by shaving and was smoothed out by using this radiofrequency wand. In this case, the wand was used as a surgical tool to complete the chondroplasty. Dr. Perrie stated that this was part of the chondroplasty procedure and does not warrant additional payment in the amount of \$1799.61 as a totally different, distinct, and unrelated procedure, and that if this procedure was an actual arthroplasty, (which it was not), payment would never be at 100%, as it would be treated as an additional procedure and would be paid at 50%. Dr. Perrie also noted that the operative report indicated that "a physician assistant was needed to optimize patient care." Dr. Perrie stated that the body of the operative report never mentioned the specific physician services that were performed and that the carrier "generously reimbursed" the PA services, according to fee schedule. Dr. Perrie stated that as per the New York State Workers' Compensation Medical Fee Schedule, Introduction and General Guidelines, Section 11C (3), the physician assistant at surgery will receive 10.7% of the total allowance for the surgical procedures. Payment is made to the employer (the physician). This is reiterated in Surgery Ground Rule 12 F. A modifier of -83 indicates the PA services at surgery. Thus, Dr. Perrie stated that for CPT code 29880, the surgeon is reimbursed in the amount of \$2471.34. Payment for the PA services would be 10.7% of this amount or \$264.43. Dr. Perrie acknowledged that the carrier incorrectly took a 50% reduction and issued payment in the amount of \$132.22. The rules call for payment of 10.7% of what is paid to the surgeon. Dr. Perrie found that this amounts to \$264.43, correctly billed in this case. Dr. Perrie also stated that for CPT code 29876, the surgeon is reimbursed in the amount of \$939.07, and thus payment for the PA services would be 10.7 % of this amount or \$100.48, and that this was paid according to the fee schedule. Dr. Perrie stated that payment is not recommended without a pathology report to support payment of this service. Dr. Perrie stated that for CPT code 29874, the surgeon was reimbursed in the amount of \$860.04. Thus, payment for the PA services would be 10.7% of this amount or \$92.02, and that this was paid in accordance with fee schedule. Dr. Perry also stated that there is no payment for CPT code 29999, as explained above.

Applicant submitted a fee schedule rebuttal by Dr. Graeme Whyte, a physician licensed to practice medicine in the State of New York, and Board Certified in the field of orthopedic surgery. Dr. Whyte stated that he is a member of Advanced Orthopaedics, PLLC. Dr. Whyte addressed the

fee schedule review conducted by Antoinette Perrie, D.C., on behalf of State Farm Insurance Company. Dr. Whyte stated that his office billed a total of four CPT codes for right knee surgery performed on January 27, 2020: 29880, 29874, 29876 and 29999, and that respondent paid all codes except for CPT code 29999 claiming it should have been billed as 29877, and in turn included in CPT code 29880, according to the denial dated 3/26/20. Dr. Whyte stated that respondent improperly halved the charge for CPT code 29880 for the physician's assistant. Dr. Whyte stated that his office seeks reimbursement of CPT code 29999, and the remainder of code 29880, since the other charges were paid. Dr. Whyte noted that respondent's fee coder denied code 29876 which was already paid by State Farm and that she conceded that State Farm incorrectly took a 50% reduction for CPT code 29880. Dr. Whyte stated that CPT code 29876 was reported in accordance with the American Academy of Orthopaedic Surgeons Global Service Data which lists the procedures included and not included within a particular CPT code. According to AAOS Global Service Data, CPT Code 29876, is not included in CPT code 29880, nor is it listed as an integral part of that procedure. Dr. Whyte further stated that the operative report describes an extensive synovectomy performed within two compartments of the knee joint to address extensive hypertrophic morbid synovitis and that this reporting is corroborated by the American Academy of Orthopaedic Surgeon guidelines, followed by a majority of orthopedic surgeons, which support the reporting of CPT code 29880 with 29876, if performed in two or more compartments. Dr. Whyte stated that the AAOS guidelines note that for code 29876, certain conditions commonly support the medical necessity for major arthroscopic synovectomy in two or more compartments not limited to those listed in the guidelines. Dr. Whyte stated that this should be documented in the records for the procedure which should note when there is extensive synovitis requiring a major synovectomy.

Dr. Whyte stated that the operative report documented the performance of extensive synovectomies within the medial and patellofemoral compartments of the knee joint to address the extensive, hypertrophic morbid synovitis encountered. According to Dr. Whyte, the synovectomies described in the operative report were extensive and not merely for visualization and developed due to the motor vehicle accident in question. Dr. Whyte stated that respondent's fee coder acknowledged that both 29876 and 29880 may be reported together in the case of pathologic synovial disease which was reported in this case. Dr. Whyte noted that the code was halved in accordance with ground rules. Dr. Whyte stated that Current Procedural Terminology (CPT) Manual requires that clinicians select the

name of the procedure or service that accurately identifies the service performed and not to select a CPT code that merely approximates the service provided. If no such procedure or service exists, then the provider is to report the service using the appropriate unlisted procedure or service code. Dr. Whyte stated that the use of an unlisted code (29999) is common when a physician performs a new procedure or utilizes new technology when no other CPT code adequately describes the procedure or service. Dr. Whyte stated that CPT code 29999, was reported to capture a coblation arthroplasty and not a chondroplasty which was alleged by the fee coder to deny the actual procedure as ultimately inclusive to CPT code 29880. Dr. Whyte stated that the coblation arthroplasty was substantiated on the second page of the operative report. Dr. Whyte stated that there is no other CPT code which best describes that work and thus CPT code 29999, was used. Dr. Whyte further stated that CPT code 29999 must be acknowledged by report (BR) as outlined in the NY Worker's Compensation Medical Fee Schedule Ground Rule 10. Dr. Whyte stated that Code 29999 is not included in another procedure and that the comparison code used to generate an RVU for the unlisted procedure was never the actual billed code nor meant to replace the unlisted 29999 code. It simply served as a reference code in order to comply with the WCB Surgery ground rule 10. Dr. Whyte further stated that The Current Procedural Terminology (CPT) Manual requires that clinicians select the name of the procedure or service that accurately identifies the service performed and not to select a CPT code that merely approximates the service provided. If no such procedure or service exists, then the service should be reported using the appropriate unlisted procedure or service code. Dr. Whyte stated that in following the aforementioned guidelines, CPT Codes 29999 was reported to capture a Coblation Arthroscopy because there is no other code which best describes the work performed. Dr. Whyte stated however, that CPT Code 29879 was used as the "comparison CPT code" for the coblation Arthroscopy performed in the patellofemoral compartment, which was documented on page 2 of the report, to reflect the same RYU, hence billing the amount of \$1,779.64. Dr. Whyte stated that a coblation arthroplasty and a chondroplasty are similar procedures performed to address articular cartilage pathologies or traumatic injuries, which may explain the reasoning of the fee coder, however, the approach in which the articular cartilage is addressed is different which makes each of these procedures distinct. Dr. Whyte stated that a coblation arthroplasty is performed with a device that is different from the one used when a chondroplasty is performed. Dr. Whyte stated that CPT code 29877 (chondroplasty) is debridement of articular cartilage performed with a motorized suction cutter, however, a coblation



arthroplasty is performed using an Arthrocare radiofrequency wand which passes current through the tip of the wand to create a plasma. According to Dr. Whyte, this plasma gets very hot which is then used to melt the articular cartilage causing minimal damage to the surrounding tissue. Dr. Whyte stated that the treatment of cartilage lesions typically involves the removal of free edges to stabilize the lesion and potentially stimulate healing depending on the depth of the lesion and that this debridement has traditionally been performed with mechanical shaving. Dr. Whyte stated that mechanical chondroplasty has been shown to provide a patient benefit, but it can lead to persistent fissures and uneven surface topography. Furthermore, over resection of potentially healthy cartilage could further damage the joint causing the lesion to progress with time. Thus, Dr. Whyte stated that a coblation was chosen as a better approach to address the articular cartilage lesion in question. Dr. Whyte stated that the method described by a coblation arthroplasty makes CPT code 29877 (chondroplasty) inappropriate to report. Therefore, a coblation arthroplasty would be reported using an unlisted service CPT code 29999, and not CPT code 29877. Dr. Whyte stated that this is corroborated by the AMA/CPT coding manual which states a physician should report the HCPCS/CPT code that best describes the procedure performed to the greatest specificity as possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. Dr. Whyte stated that the AMA/CPT describe CPT code 29877 as "debridement/shaving of articular cartilage (chondroplasty)", but it does not mention a Coblation Arthroscopy. Dr. Whyte stated that the coblation arthroplasty was performed in the patellofemoral compartment and the service package for CPT code 29880, for medial meniscectomy does not describe the procedure according to Global Service Data. Dr. Whyte noted that the charge is subject to ground rule 5, reducing the charge to \$889.82. In total, \$132.22 allowed by the coder for CPT code 29880, plus \$889.82 and \$95.21 for code 29999, amounts to a total of \$1,117.25, payable.

This arbitrator has considered respondent's fee audit by Antoinette Perrie, D.C., Lac, CPC, who is a chiropractor and acupuncturist as well as the fee schedule rebuttal by Dr. Grame Whyte, M.D., who is an orthopedic surgeon, and finds that applicant adequately refuted respondent's fee coder's analysis with specificity, describing the surgical procedures performed and the basis for utilizing the foregoing codes. Accordingly, applicant is awarded the differential in the amount of \$1,117.24. Attorney's fees shall be calculated pursuant to 11 NYCRR 65-4.6 (d). Interest shall be calculated



from September 4, 2020, which is the AR1 filing date. See, 11 NYCRR 65-3.9 (c).

**DECISION: APPLICANT IS AWARDED REIMBURSEMENT IN THE AMOUNT OF \$1,117.24, WITH ATTORNEY'S FEES AND INTEREST.**

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
	Advanced Orthopaedics PLLC	01/27/20 - 01/27/20	\$2,007.06	\$1,117.24	Awarded: \$1,117.24
Total			\$2,007.06		Awarded: \$1,117.24

- B. The insurer shall also compute and pay the applicant interest set forth below. 09/04/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

See, the within award.

C. Attorney's Fees

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

See, the within award.

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

05/02/2021  
(Dated)

Pamela Hirschhorn

**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:**  
b3d121deb3fd9cb8efe2754bd001fb20

### **Electronically Signed**

Your name: Pamela Hirschhorn  
Signed on: 05/02/2021