American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Advanced Orthopaedics PLLC (Applicant)	AAA Case No.	17-19-1121-6979
	Applicant's File No.	RFA18-223925
- and -	Insurer's Claim File No.	32-3678-B74
	NAIC No.	25178
State Farm Mutual Automobile Insurance Company (Respondent)		

ARBITRATION AWARD

I, Victor Moritz, 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: IP

1. Hearing(s) held on 05/06/2021
   Declared closed by the arbitrator on 05/06/2021

   Helen Feingersh, Esq. from Russell Friedman & Associates LLP participated by telephone for the Applicant

   Michele Rita, Esq. from Rivkin & Radler LLP participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 3,010.53**, 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 applicant's claim concerns a fee schedule dispute regarding a left shoulder arthroscopic procedure provided to the IP (W.R. 57 year old female) on July 6, 2018, relative to a March 27, 2018 motor vehicle accident. The sole issue concerns the proper reimbursement rate for this procedure. This matter is determined after reviewing the admissions and presentations of both sides. I have reviewed the documents contained in the electronic case folder as of the closing of the file.

4. Findings, Conclusions, and Basis Therefor

I find for the applicant and award the sum of $1091.37 as the additional amount owed for this procedure.

I note that an arbitrator need not adhere with strict conformity to the evidentiary rules set forth in CPLR 2016 see Auto One Ins. Co., v Hillside Chiropractic P.C. 126 A.D. 3d. 423 (1st Dep't, 2015) citing 11 NYCRR 65-4.5 (o) the arbitrator shall be the judge of the relevance and materiality of the evidence offered.

Fee Schedule

The defendant has the burden to come forward with competent evidentiary proof to support its fee schedule defenses. Robert Physical Therapy, P.C. v. State Farm Mut. Auto. Ins. Co., 13 Misc. 3d. 172(Civ. Ct. Kings Co. 2006). A lay person is not qualified to evaluate the CPT codes or to change if the code is used by a health provider in its bills. See Abraham v. Country-Wide Ins. Co., 3 Misc. 3d. 130A (App. Term 2d. Dept. 2004).When a defendant fails to demonstrate by competent evidentiary proof that a plaintiff's claim was in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedule cannot be sustained. Continental Medical, P.C. v. Travels Indemnity Co., 11 Misc. 3d.145A (App. Term 1st Dept. 2006).

While amended Regulations section 65-3.8(g)(1) states proof of the fact, and amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances: … (ii) for those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers; I do not believe the amended regulations were put into effect to shift the burden from the respondent to establish that a charge submitted by the applicant was above fee schedule. To do so would be to erode the holding in Viviane Etienne Med. Care v Country-Wide Ins. Co. 25 NY3d 498, 501 (2015) and to de facto require the applicant to establish the fee schedule for the service provided as an element of their prima facie case. I believe the regulations were put into effect to prevent an applicant from receiving reimbursement for a service provided at a rate clearly in excess of the fee schedule where the respondent issued an untimely or even failed to issue any denial for the service.

In support of the respondent's position concerning the proper reimbursement rate for the surgical procedure, the carrier has submitted an affidavit from Kimberly Spahr, certified professional coder, (CPC) attesting to her credentials and accreditations. In terms of this procedure, she notes the amendment to the regulations concerning fee schedule which have been discussed in other matters.

In this instance, the applicant undertook a left shoulder arthroscopic procedure billed under CPT code 29823-athrtoscopy shoulder surgical; debridement extensive was billed at $1,878.13; CPT code 29825-modifier 59 arthroscopy shoulder surgical with lysis resection of adhesions with or without manipulation was at $936.77; and CPT code 29821-modifier 51 arthroscopy shoulder surgical synovectomy complete was billed at

$889.82; (CPT code 29999 unlisted procedure-extensive bursectomy billed at $1,572.48 and a second CPT code 29999 unlisted procedure-lysis of thickened coracoacromial ligament billed at $548.23.

Pertinent to the resolution of this matter, 11 NYCRR § 65-3.8 noting that the proof of the fact and the amount of loss sustained pursuant to Insurance Law § 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances… (ii) For those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law §§ 5108(a) and (b) and the regulations promulgated. Further pursuant to 11 NYCRR 65-3.8(g)(1) these sections are applicable to all matters rendered on or after April 1, 2013.

The 33rd Amendment went into effect on 01-23-18, subsequent to the date the procedure herein was performed and it pertains to health services performed outside New York State **on** or after that date (emphasis added).

As a result of the Amendment, 11 NYCRR §68.6 was modified and currently reads as follows:

(a)(1) If a professional health service reimbursable under Insurance Law 5102 (a)(1) is performed outside this State, the amount that the insurer shall reimburse for the service shall be the lower of the amount charged by the provider and the prevailing fee in the geographic location of the provider with respect to services:

(i) that constitute emergency care;

(ii) provided to an eligible injured person that is not a resident of this State; or

(iii) provided to an eligible injured person that is a resident of this State who, at the time of treatment, is residing in the jurisdiction where the treatment is being rendered for reasons unrelated to the treatment….

(b) Except as provided in subdivision (a) of this section, if a professional health service reimbursable under Insurance Law section 5102 (a)(1) is performed outside this State with respect to an eligible injured person that is a resident of this State, the amount that the insurer shall reimburse for the service shall be the lowest of:

(1) the amount of the fee set forth in the region of this State that has the highest applicable amount in the fee schedule for that service;

(2) the amount charged by the provider; and

(3) the prevailing fee in the geographic location of the provider.

(c) If the jurisdiction in which the treatment is being rendered has established a fee schedule for reimbursing health services rendered in connection with claims for motor

vehicle-related injuries and the fee schedule applies to the service being provided, the prevailing fee amount specified in subdivisions (a) and (b) of this section shall be the amount prescribed in that jurisdiction's fee schedule for the respective service.

Under these circumstances, the applicant is seeking reimbursement for medical services rendered under a New York State Automobile Insurance policy provided to the IP, a resident of Bronx, New York, by an entity located in New Jersey.

Therefore, reimbursement is limited to **the lesser amount allowed** (emphasis added) under the prevailing rate for the geographic location of the Provider, the amount billed by the Provider or the highest amount allowable under the New York State Workers' Compensation fee schedule (Region IV).

The parties acknowledge the New York State Workers' Compensation fee schedule (Region IV) governs this claim.

Ms. Spahr indicates that CPT code 29823 is considered an integral component of the other services (29821 and 29825) and thus is not separately reimbursable. Therefore, CPT code 29825 has been corrected as the primary procedure for this session and accorded the highest value. Finally, CPT code 29821 was property reimbursed. In terms of CPT code 29999 she notes that may only be reported once per the rules noting that as follows "when performing two or more procedures that require the use of the same unlisted code the unlisted code used should only be reported once to identify the service. This is due to the fact that unlisted codes do not identify specific unit value or service. Unit values are not assigned to unlisted codes since the codes do not identify usual procedural components or the effort/skill required for the service. When reporting an unlisted code to describe a procedure or service, it is necessary to submit supporting documentation along with the claim to provide an adequate description of the nature extent and need for the procedure, and the time, effort and equipment necessary to provide the service." Ms. Spahr opines that this item should be given a by-report (BR) code with a relative value that are too variable in nature to be assigned a specific relative value unit. Therefore, pertinent information concerning the nature, extent and need for the procedure or service, the time skill and equipment necessary must be furnished. In this case, a detailed clinical record is not necessary but sufficient information shall be submitted to permit a proper evaluation. In this case, the provider failed to provide any of this information and the correct reimbursement for this service should be billed under 29826 with a relative value unit of 1.97. This is also subject to the multiple procedure rules. Noting when multiple procedures unrelated to the major procedure and any significant time or complexity are provided at the same operative session payment is for the procedure with the highest value plus half of the lesser procedure. She continues that in this case CPT code 29826 would be most appropriate for the items billed under 29999 noted this is an arthroscopy shoulder surgical decompression subacromial space with partial acromioplasty with coracoacromial ligament release.

CPT code 29825 with a $229.04 conversion factor (CF) multiplied by the relative value units (RVU) of 8.18 allows for $1873.55. CPT code 29821 with CF $229.04 multiplied by 7.77 RVU multiplied by 50% for the multiple procedure rules (surgical ground rule 5) allows for $889.82 and finally CPT code 29999-billed as extensive bursectomy was

found by Ms. Spahr to be most appropriately billed with a 1.97 RVU multiplied by CF $229.04 and the 50% multiple procedure rule allows for $225.61 thus a total of $2,988.98. The respondent acknowledged payment of $2,814.90 thus respondent's own reviewer indicates an additional $174.08 is owed.

In opposition, I note the affidavit from Dr. Dov Berkowitz, the orthopedic surgeon who performed this procedure. Initially, Dr. Berkowitz misstates the respondent's position stating the carrier conceded reimbursement, for CPT codes 29823 and 29825 as billed. As noted, the respondent awarded the applicant additional amounts for CPT code 29825 and denied in total CPT code 29823 as being included in the services billed under CPT codes 29821 and 29825. Therefore, Dr. Berkowitz's discussion as to these codes is immaterial to the determination of this claim.

Concerning the use of CPT code 29999 for the bursectomy as well as for the lysis of the thickened coracoacromial ligament, Dr. Berkowitz noted disagreed with Ms. Spahr's assessment that these additional procedures were not supported by the medical records; noting the operative report identifies and illustrates the procedures he performed.

In terms of CPT code 29999 it is noted that while code 29825 was performed in the same compartment it did not include an extensive bursectomy which was also provided for the patient herein as well as lysis of the coracoacromial ligament. Therefore, the basis for providing two coding items at the CPT code 29999.

Dr. Berkowitz states that these items were billed comparatively using code 29822 for the bursectomy in the subacromial space and 23415 for a lyses of a thickened coracoacromial ligament. He continues that it is inappropriate to try to bundle these procedures using RVU for 29826 noting this is not accurately described the procedures that were performed on the patient. CPT code 29826 is a subacromial decompression and an extensive bursectomy as performed for this patient is not a subacromial decompression. Further, CPT code 29826 acromioplasty would have been performed which was also not done in this case. Thus, the utilization of CPT code 29826 is not appropriate. In this case, CPT code 29999 was properly billed to allow for proper reimbursement for the procedures performed.

Accordingly, Dr. Berkowitz indicates the reimbursement rates for CPT code 29823 with an RVU of 8.2 multiplied by the $229.04 CF at 100% allows for $1,878.13, CPT code 29825 with an RVU of 8.18 multiplied by the CF $229.04 and 50% for the multiple procedure rule equals $936.77. CPT code 29821 with an RVU of 7.77 multiplied by $229.04 CF and 50% equals $889.82.

Further, CPT code 29999 utilizing code 29822 for reimbursement with an RVU of 7.55multiplied by $229.04 CF and 50% equals $864.63. Finally, CPT code 29999 using code 23415 with an RVU of 3.95 multiplied by $299.04 CF and 50% equals $452.35. The applicant believes the proper reimbursement rate for this service if $5,021.70 less the $2,814.90 paid totaling $2,206.80.

Conclusions

In the instant matter, I find for the applicant award the additional sums billed for CPT codes 29999 for the bursectomy as well as for the lysis of the thickened coracoacromial ligament. The additional amount sought for CPT code 29823- arthroscopy shoulder surgical; debridement extensive is denied as being incorporated in the other procedures. Concerning CPT code 29823, Ms. Spahr's affidavit is specific that it is incorporated in services billed under CPT codes 29821 and 29825 and I find the applicant has not sufficiently refuted this determination and therefore that portion of the claim is denied.

As to CPT codes 29999- bursectomy-extensive and lysis of the thickened coracoacromial ligament, Dr. Berkowitz provided specific bases as to why he billed the services in the manner he did and I believe it is sufficient to refute Ms. Spahr's affidavit.

At the outset Ms. Spahr's affidavit indicates as follows "This review is to determine the allowable amount per the fee schedule. The reviewer is not a medical professional, able to make medical determinations on behalf of her patient care. No medical records were reviewed for this review, except where noted. The report is solely based on the billing and coding guidelines set forth by the New York State Worker's Compensation Board, Department of Health, CMS and the AMA. In no way does the report reflect on the outcome of medical necessity."

Accordingly, Dr. Berkowitz noted while code 29825 was performed in the same compartment it did not include an extensive bursectomy which was also provided for the patient herein as well as lysis of the coracoacromial ligament. Therefore, the basis for providing two coding items at the CPT code 29999.

Dr. Berkowitz states that these items were billed comparatively using code 29822 for the bursectomy in the subacromial space and 23415 for a lyses of a thickened coracoacromial ligament. He continues that it is inappropriate to try to bundle these procedures using RVU for 29826 noting this is not accurately described the procedures that were performed on the patient. CPT code 29826 is a subacromial decompression and an extensive bursectomy as performed for this patient is not a subacromial decompression.

In sum, I find Dr. Berkowitz's affidavit is sufficient to refute the determinations by the respondent's coder.

Therefore, the applicant is reimbursed CPT codes 29999 at the rate of $864.63 and $452.35 less the amount paid by the carrier for these items of $225.61.

Accordingly, the applicant is awarded the sum of $1091.37.

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**
	Advanced Orthopaedics	**07/06/18 - 07/06/18**	**$3,010.53**	**Awarded: $1,091.37**
Total			**$3,010.53**	**Awarded: $1,091.37**

B. The insurer shall also compute and pay the applicant interest set forth below. 03/06/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The respondent shall pay interest at a rate of two percent per month, simple on a pro rata basis using a thirty day month. With respect to the claim herein, interest will run from March 6, 2019, the date of the filing of this claim through payment of the claim.

C. Attorney's Fees

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

As this matter was filed **after**February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 11 NYCRR 65-4.6(d).

With respect to this claim, the applicant is entitled to attorney's fees for the medical services provided to the IP for which the applicant is awarded the sum of $1091.37.

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 Westchester

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

05/16/2021
(Dated)

Victor Moritz

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:
a076f8133e678bfb91b004757bcd8a84

Electronically Signed

Your name: Victor Moritz
Signed on: 05/16/2021