

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Advanced Orthopedics & Joint Preservation
PC
(Applicant)

- and -

State Farm Mutual Automobile Insurance
Company
(Respondent)

AAA Case No.	17-20-1168-6298
Applicant's File No.	BT20-111073
Insurer's Claim File No.	32-C294-5N9
NAIC No.	25178

ARBITRATION AWARD

I, Sandra Adelson, 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 patient

1. Hearing(s) held on 07/29/2021
Declared closed by the arbitrator on 07/29/2021

Jonathan Buckley, Esq.. from The Tadchiev Law Firm, P.C. participated for the Applicant

Luke Harkins, Esq. from James F. Butler & Associates participated for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 4,424.58**, 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 seeks payment for the balance due for left knee surgery performed on 2/20/20 by the surgeon and the physician's assistant.

The respondent asserted a fee schedule defense and remitted payment of \$5,087.43.

4. Findings, Conclusions, and Basis Therefor

The record consisted of claimant's submission, respondent's submission, as well as documents not enumerated within this decision, but which are contained in the case file maintained by the American Arbitration Association. THE ARBITRATOR SHALL BE THE JUDGE OF THE RELEVANCE AND MATERIALITY OF THE EVIDENCE OFFERED pursuant to 11 NYCRR 65-4.5 (o) (1) (Regulation 68-D). 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. Based on a review of the documentary evidence, this claim is decided as follows:

A presumption of medical necessity attaches to a timely submitted no fault claim. All County Open MRI & Diagnostic Radiology. P.C. v. Travelers Ins. Co., 11 Misc. 3d 131[A], 815 N.Y.S.2d 493 (App.Term 9th & 10th Jud. Dists. 2006). The burden then shifts to the defendant to rebut the presumption of medical necessity. A.B. Medical Services PLLC v. Utica Mut. Ins. Co., 10 Misc 3d 50, 809 N.Y.S.2d 765 (App.Term 2nd & 11th Jud. Dists. 2005); and A Plus Medical, P.C. v. Government Employees Ins. Co., 21 Misc 3d 799, 870 N.Y.S.2d 858 (Civil Ct. Kings Co. 2008).

In order to meet this burden, the defendant must establish the treatment or tests in question were not in accordance with generally accepted medical/professional practice. Delta Medical Supplies, Inc. v. NY Central Mutual Ins. Co., 14 Misc. 3d 1231[A], 836 N.Y.S.2d 492 (Civil Ct. Kings Co. 2007); and CityWide Social Work & Psychological Servs. V. Travelers Indem. Co., 3 Misc 3d 608, 777 N.Y.S.2d 241 (Civil Ct. Kings Co. 2004). The respondent asserted a fee schedule defense.

In support of respondent's fee schedule defense, respondent submitted the professional fee coder affidavit from Judith Cole, CPC. Applicant's submission did not include a coder affidavit, rebuttal certified professional coder affidavit or evidence in support of its fee schedule claim. However, upon a review of the detailed and comprehensive fee coder affidavit of Judith Cole, CPC submitted on behalf of respondent, I am constrained to find that Ms. Cole's computations, explanation and fee schedule analysis was detailed and complete.

I, therefore, choose to abide by her analysis that the surgeon was entitled to \$4595.69 and that the physician's assistant was due \$491.74 or \$5087.43 for this claim. Therefore, Ms. Cole correctly concluded that not additional money was due applicant for the services in issue.

Ms. Cole's certified professional coder affidavit stated the following:

"Dates of service 2/20/20 was billed in the amount of \$8,554.40

The provider billed CPT codes 29880, 29855-51, 29876-51, 29877-51, 76000-51, and 20610-51.

Note: Per the New York Workers' Compensation Medical Fee Schedule Surgery Ground Rule #5, "when 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 the lesser procedures."

- The provider billed CPT code 29880. Based on the operative report, this code is correct and reimbursable at 100% according to the NY Workers' Compensation Medical Fee Schedule Surgery Ground Rule 100% listed above.

Therefore, the accurate reimbursement entitled for CPT code 29880-LT is \$2,471.34, calculated utilizing the RVU of 10.79 x Conversion Factor of 229.04 = 2,471.34.

- The provider billed CPT code 29855-51. According to the AMA CPT Assistant (Copyright 1995-2019 American Medical Association. All rights reserved.), the correct full description of CPT 29855 is "Arthroscopically aided treatment of tibial fracture, proximal (plateau); epicondylar, includes internal fixation, when performed (includes arthroscopy)". Based on the operative report this procedure was conducted and this code is accurate to use. This is a lesser value procedure and is reimbursable at 50%.

It is necessary to append Modifier -51 to CPT code 29855 to indicate multiple procedures have been performed at the same session by the same provider.

Therefore, the accurate reimbursement entitled for CPT code 29855-51-LT is \$1,185.28, calculated utilizing the RVU of 10.35 x Conversion Factor of 229.04 = 2,370.56 x 50% = 1,185.28.

- Provider billed CPT code 29876. According to the AMA CPT Assistant (Copyright 1995-2019 American Medical Association. All rights reserved.), the correct full description is "Arthroscopy, knee, surgical; synovectomy, major 2 or more compartments (eg. medial or lateral)". Based on the operative report, synovectomy was performed within, both the medial and lateral compartments of the left knee.

Therefore, the accurate reimbursement entitled for CPT code 29876-51-LT is \$939.06, calculated utilizing the RVU of 8.20 x Conversion Factor of 229.04 = 1,878.13 x 50% = \$939.07.

- Provider billed CPT code 29877-51. Based on the operative report, the chondroplasty was performed in the patellofemoral compartment. All other arthroscopic procedures were performed in both the lateral and medial compartments.

Per CPT Book, the higher value procedure (CPT code 29880) includes the "chondroplasty, same or separate compartment (s)". CPT code 29877 cannot be "unbundled" and billed separately from the meniscectomy of both the medial and lateral meniscus. AMA and AAOS NOW bundles CPT 29877 with 29880 currently.

Therefore, the accurate reimbursement entitled for CPT code 29877 is \$0.00

- The provider billed CPT code 76000-51. According to the AMA CPT Assistant (Copyright 1995-2019

- American Medical Association. All rights reserved), correct full description is "Fluoroscopy (separate procedure), up to 1 hour physician or other qualified healthcare professional time". Based on the operative report this procedure was conducted as part of a normal arthroscopic procedure and is not separately reimbursable.

Note: Per the New York Workers' Compensation Medical Fee Schedule Surgery Ground Rule #7, "Certain procedures are an inherent portion of a procedure or service, and, as such, do not warrant a separate charge."

Therefore, the accurate reimbursement entitled for CPT code 76000 is 0.00.

- Provider billed CPT code 20610-51. According to the AMA CPT Assistant (Copyright 1995-2019 American Medical Association. All rights reserved.), the correct full description of CPT 20610 is "Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g. shoulder, hip, knee, subacromial bursa), without ultrasound guidance." Based on the operative report this procedure was conducted as part of a normal arthroscopic procedure and is not separately reimbursable.

Note: Per NYS Workers' Compensation Board 's Surgery Ground Rule #1B Package and Global Fee Concept, states "Listed values for all surgical procedures include the surgery, local infiltration, digital or regional block, and/or topical anesthesia when used" indicates any injections performed during a normal course of surgery are part of the Global Package and not separately reimbursable.

Therefore, the accurate reimbursement entitled for CPT code 20610 is 0.00.

The total allowable amount per the NY fee schedule for Bill #1 DOS 2/20/20 is \$4,595.69.

Bill #2:

Provider is a Physician Assistant employed by the Orthopedic Surgeon The highest conversion factor for Surgery = \$229.04

Dates of service 2/20/20 was billed in the amount of \$957.61

The provider billed CPT codes 29880, 29855-51, 29876-51, 29877-51, 76000-51, and 20610-51; with modifier -83.

Note: Per the New York Workers' Compensation Medical Fee Schedule Surgery Ground Rule #12(F), Physician Assistants and Nurse Practitioner: "Services of physician assistants and nurse practitioners assisting during surgical procedures will be paid at two-thirds of the surgical assistant percentage (16.0 percent). Physician assistants will receive 10.7 percent of the total allowance for the surgical procedures. Payment will be made to the physician assistants' and nurse practitioner' s employer (the physician)."

- The provider billed CPT code 29880. Based on the operative report, this code is correct and reimbursable at 10.7% of the primary surgeon's allowance for the procedure according to the NY Workers' Compensation Medical Fee Schedule Surgery Ground Rule #12 listed above.

Therefore, the accurate reimbursement entitled for CPT code 29880-LT is \$264.43, calculated utilizing the RVU of 10.79 x Conversion Factor of 229.04 = 2,471.34 x 10.7% = \$264.43.

- The provider billed CPT code 29855-51. Based on the operative report this procedure was conducted and this code is accurate to use.

It is necessary to append Modifier -51 to CPT code 29855 to indicate multiple procedures have been performed at the same session by the same provider.

Therefore, the accurate reimbursement entitled for CPT code 29855-51-83-LT is \$126.83, calculated utilizing the RVU of 10.35 x Conversion Factor of 229.04 = 2,370.56 x 50% = \$1,185.28 x 10.7% =

\$126.83.

- Provider billed CPT code 29876. Based on the operative report, synovectomy was performed within, both the medial and lateral compartments of the left knee.

Therefore, the accurate reimbursement entitled for CPT code 29876-51-83-LT is \$100.48, calculated utilizing the RVU of 8.20 x Conversion Factor of 229.04 = 1,878.13 x 50% = \$939.07 x 10.7% = \$100.48.

- Provider billed CPT code 29877-51. Based on the operative report, the chondroplasty was performed in the patellofemoral compartment. All other arthroscopic procedures were performed in both the lateral and medial compartments.

However, per CPT Book, the higher value procedure (CPT code 29880) includes the "chondroplasty y, same or separate compartment (s)". CPT code 29877 cannot be "unbundled" and billed separately from the meniscectomy of both the medial and lateral meniscus. AMA and AAOS NOW bundles CPT 29877 with 29880 currently.

Therefore, the accurate reimbursement entitled for CPT code 29877 is \$0.00

- The provider billed CPT code 76000-51. Based on the operative report this procedure was conducted as part of a normal arthroscopic procedure and is not separately reimbursable.

Note: Per the New York Workers' Compensation Medical Fee Schedule Surgery Ground Rule #7, "Certain procedures are an inherent portion of a procedure or service, and, as such, do not warrant a separate charge."

Therefore, the accurate reimbursement entitled for CPT code 76000 is 0.00.

- Provider billed CPT code 20610-51. Based on the operative report this procedure was conducted as part of a normal arthroscopic procedure and is not separately reimbursable.

Note: Per NYS Workers' Compensation Board's Surgery Ground Rule #1 B Package and Global Fee Concept, states "Listed values for all surgical procedures include the surgery, local infiltration, digital or

regional block, and/or topical anesthesia when used indicates any injections performed during a normal course of surgery are part of the Global Package and not separately reimbursable.

Therefore, the accurate reimbursement entitled for CPT code 20610 is 0.00.

The total allowable amount per the NY fee schedule for Bill #2 DOS 2/20/20 is \$491.74.

Therefore, the combined allowable amount of Bill #1 & #2 per the NY fee schedule for DOS 2/20/20 is \$5,087.43"

Pursuant to the 33rd Amendment, the calculated New York amount was lower than the New Jersey calculation and the claim had been correctly paid for \$5087.43. No additional moneys are due applicant.

The claim is denied.

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 Suffolk

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

08/25/2021
(Dated)

Sandra Adelson

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:
e74d8812fc1d7c4180630dbd7d0cdc6e

Electronically Signed

Your name: Sandra Adelson
Signed on: 08/25/2021