American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Hank Ross Medical PC (Applicant)	AAA Case No.	17-21-1194-7738
	Applicant's File No.	3102945
- and -	Insurer's Claim File No.	20-5454715
	NAIC No.	24279
Progressive Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Antonietta Russo, 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 07/01/2022
   Declared closed by the arbitrator on 07/01/2022

   Melissa Scotti from Law Offices of Andrew J. Costella Jr., Esq. participated in person for the Applicant

   Regina Wilcox from Progressive Casualty Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$1,058.17**, 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, a 26-year-old female driver, was reportedly involved in a motor vehicle accident on June 4, 2020. Following the accident, Assignor suffered injuries which resulted in her seeking medical treatment. This dispute arises from a claim for a left knee arthroscopy performed on November 9, 2020. Applicant is seeking reimbursement for these services. Respondent partially paid the claims and denied the remaining balance on a fee schedule defense. Applicant is seeking reimbursement for the unpaid balance. The only issue presented at the hearing was:

1) Whether Respondent properly denied payment based on the fee schedule?

4. Findings, Conclusions, and Basis Therefor

The Applicant and the Respondent submitted documentary evidence in support of their respective positions. All such evidence is contained within MODRIA maintained by the American Arbitration Association, as of the date of the hearing. The below-noted decision is based upon my review of the submitted evidence, along with the oral argument of the representatives present at the hearing.

It is now well settled that Applicant establishes "a prima facie showing of their entitlement to judgment as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue." *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2d Dep't. 2004). In the case at bar, Applicant has met this burden.

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 a claim. See *New York Hosp. Med. Ctr. of Queens v. Country-Wide Ins.* Co., 295 A.D.2d 583, 586 (2002); *East Coast Acupuncture, P.C. v. New York Cent. Mut. Ins.,* 2008 NY Slip Op 50344(U) (App. Term 2d Dep't., Feb. 21, 2008); *A.B. Med. Servs., PLLC v. American Tr. Ins. Co*., 15 Misc.3d 132(A), 2007 NY Slip Op 50680(U) (App. Term, 2nd & 11th Jud Dists. 2007); *Rigid Medical of Flatbush, P.C. v. New York Cent. Mut. Fire Ins. Co*., 11 Misc.3d 139(A), 816 N.Y.S.2d 700, 2006 NY Op 50582 (U) (App. Term 2nd & 11th Jud Dists. 2006); *Ultra Diagnostics Imaging v. Liberty Mut. Ins. Co.,* 9 Misc.3d 97, 98, 804 N.Y.S.2d 532, 2005 N.Y. Slip Op. 25402 (App Term, 2d Dep't.); *Capio Med., P.C. v Progressive Cas. Ins. Co.*, 7 Misc 3d 129[A], 2005 NY Slip Op 50526 (U) (2005); *Triboro Chiropractic & Acupuncture, PLLC v New York Cent. Mut. Fire Ins. Co.,* 6 Misc.3d 132 (A), 2005 NY Slip Op 50110 (U) (App Term, 2nd & 11th Jud Dists 2005).

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 a plaintiff's claims were in excess of the appropriate fee schedules, defendant'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).

The evidence demonstrates that Applicant billed under CPT codes 29870, 29999, and 20610. The Applicant acknowledges payment in the amount of $990.00 and seeks the remainder of the claim; however, Respondent disagrees and asserts that Applicant was correctly reimbursed and no further payment is due.

In support of their contentions, Respondent relied on an affidavit by Ms. Alice Downing, Certified Professional Coder. According to Ms. Downing, CPT codes 29870 and 20610 are included in another code. Her affidavit states:

> For date of service November 9, 2020, Progressive received surgery billing for the services provided by the physician. The following surgical procedures were billed:
>
> 29870 mod LT Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
>
> 29999 mod LT Unlisted procedure, arthroscopy
>
> 20610 mod LT Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance…
>
> Code 29999 (unlisted procedure, arthroscopy) is classified in the Worker's Compensation Fee Schedule as having a BR value. The fee schedule indicates in Ground Rule #3 of the Introduction and General Guidelines Section regarding By Report codes, "For any procedure where the relative value unit is listed in the schedule as "BR" the physician shall establish a relative value unit consistent in relativity with other relative value units shown in the schedule." The ground rule also states, "Fees for such procedures need to be justified 'by report'."
>
> By Report (BR) code billed 29999: The physician submitted information indicating the comparative relative value for the BR code billed is the same as 29879 which is 7.77. This would be the relative value used in order to calculate the allowable fee for the procedure performed…

> the CPT book provides further explanation of descriptive terms and identifying codes. Code 29870 should be denied, "Per CPT, Surgical endoscopy/arthroscopy always includes a diagnostic endoscopy/arthroscopy."
>
> As outlined above, the CPT Assistant may offer more clarity on coding issues. A CPT Assistant article from April 2017 indicates that it is not appropriate to report code 20610, Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa); without ultrasound guidance, when performed concurrent with another intra-articular procedure. Moreover, local infiltration of medications for postoperative pain management, with or without the addition of other medications (eg, steroid), is inherent to all surgical procedures and, therefore, is not separately reportable.

Based on Ms. Downing's recommendation, Respondent reimbursed Applicant in the amount of $990.00 and argues no further reimbursement is due.

Alternatively, to support their claim, Applicant relies on the affirmation by Dr. Hank Ross (the treating physician) that indicate the surgery was a complex orthopedic/medical issue regarding separate/inclusive procedures and beyond the understanding of person lacking in medical school education. He further commented that "a non-physician" coder fails to understand that a surgical endoscopy/arthroscopy does not always include a diagnostic procedure. Dr. Ross further states the procedures herein (CPT code 29870 & 20610) would justify using Modifier 59. The CPT codes in dispute as procedures categorized, labeled, and performed are "both orthopedically-undisputed and medically-identified separate surgical procedures."

After careful consideration of the evidence, I find for Respondent. Although Applicant's affirmation indicated the reasoning and utilization for modifier 59, the billing provided does not contain said modifier. Moreover, Dr. Ross did not offer a credible analysis regarding the proper fee. He did not suggest an alternate fee and only stated that the unpaid codes were not inclusive of the paid code. Additionally, he did not discuss the CPT book or CPT Assistant. Therefore, weighing the evidence of both parties, I find Ms. Downing's affidavit more persuasive as to the proper fee schedule amount and therefore, the claim is denied.

Any further issues raised in the record are held to be moot and/or waived insofar as not raised at the time of the hearing. This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

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

07/29/2022
(Dated)

Antonietta Russo

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:
e108b731f9b4a3666e8e66741058ca4e

Electronically Signed

Your name: Antonietta Russo
Signed on: 07/29/2022