American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

William L. King, M.D. P.C. (Applicant)	AAA Case No.	17-22-1254-4131
	Applicant's File No.	112650
- and -	Insurer's Claim File No.	96642-02
	NAIC No.	24309
Hereford Insurance Company (Respondent)		

ARBITRATION AWARD

I, Kihyun Kim, 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 Assignor

1. Hearing(s) held on 03/16/2023
   Declared closed by the arbitrator on 03/16/2023

   John Faris, Esq. from Law Offices of Eitan Dagan participated virtually for the Applicant

   Joseph Kuroly, Esq. from Law Offices of Rubin & Nazarian participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$8,961.07**, 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 issue presented is whether Applicant's claims were properly billed and paid according to the fee schedule.

   The Assignor (AS) was a 24-year-old female who was a passenger in an automobile that was involved in an accident on December 31, 2021. Applicant seeks reimbursement in the aggregate amount of $8,961.07 for the balance of the charges that were partially paid by Respondent for an office evaluation and pulse oximetry testing of the Assignor conducted on March 28, 2022, and for the surgeon and assistant services related to an arthroscopy of the left shoulder of the Assignor conducted on April 25, 2022.

4. Findings, Conclusions, and Basis Therefor

This arbitration was conducted using the documentary submissions of the parties contained in the ADR Center, maintained by the American Arbitration Association. I have reviewed the documents contained therein as of the closing of the hearing, and such documents are hereby incorporated into the record of this hearing. The hearing was held by Zoom video conference. Both parties appeared at the hearing by counsel, who presented oral argument and relied upon their documentary submissions. There were no witnesses.

The Assignor was a 24-year-old female who was injured in an automobile accident on February 15, 2019. The next day, the Assignor went to the emergency room, where she was evaluated, treated and released without admission. X-rays were apparently taken but no fractures were noted. The Assignor later sought treatment and testing for her injuries from other various providers, who started her on a course of conservative care, including physical therapy, and acupuncture.

On March 28, 2022, Applicant conducted an office evaluation and pulse oximetry testing of the Assignor. Applicant billed Respondent for its services related to the surgery, and Respondent paid APplicant's claims in part and denied the remainder based on a fee schedule dispute.

On April 25, 2022, the Assignor underwent an arthroscopy of the left shoulder performed by William L. King, M.D. and assisted by Pawel Hanulewicz, P.A., at an ambulatory surgery center in Brooklyn, New York. Applicant billed Respondent for the surgeon and assistant services related to the surgery. There is no denial in the record for the bill at issue but Respondent does not deny receipt of the bill at issue.

Applicant now seeks reimbursement in the aggregate amount of $8,961.07 for the balance of the charges that were partially paid by Respondent for an office evaluation and pulse oximetry testing of the Assignor conducted on March 28, 2022, and for the surgeon and assistant services related to an arthroscopy of the left shoulder of the Assignor conducted on April 25, 2022.

Legal Framework - Fee Schedule

It is well established that a healthcare provider must limit its charges according to the applicable fee schedule. *Goldberg v. Corcoran*, 153 AD2d 113, 117-18 (App Div, 2d Dept 1989). Amended Regulation 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: (i) when the claimed medical services were not provided to an injured party; or (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. This subdivision applies to medical services rendered on or after April 1, 2013.

Notwithstanding the foregoing, the insurer 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). In the absence of such proof, a defense of noncompliance with the appropriate fee schedule cannot be sustained. *Continental Medical, P.C. v. Travelers Indemnity Company*, 11 Misc. 3d 145(A), 2006 N.Y. Slip Op. 50841(U) (App. Term 1st Dept. 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). Once the insurer makes a prima facie showing that the amounts charged by a provider were in excess of the fee schedule, the burden shifts to the provider to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. *Cornell Medical, P.C. v. Mercury Casualty Co.*, 24 Misc. 3d 58, 884 N.Y.S.3d 558 (App. Term 2d, 11th &13th Dists. 2009).

Analysis - Fee Schedule - Office/Pulse Oximetry - DOS 3/28/22

In the present case, Applicant apparently billed Respondent in the aggregate amount of $314.29 under CPT Codes 99205 and 94760 for an office evaluation and pulse oximetry testing of the Assignor conducted on March 28, 2022. Respondent partially paid Applicant's claims in the amount of $251.44 but timely denied the remainder ($62.85) based on a fee schedule dispute. Respondent uploaded a fee schedule/coder affidavit, sworn to on September 5, 2022, by John L. Cerf, D.C., C.P.C., who concedes that the allowable reimbursement for CPT Code 99205 is $274.99 and for CPT Code 94760 is $39.30, or a total of $314.29, which is exactly what Applicant billed Respondent in this case for its services. Accordingly, Applicant is awarded additional reimbursement in the aggregate amount of **$62.85** for the balance of the charges that were partially paid by Respondent for an office evaluation and pulse oximetry testing of the Assignor conducted on March 28, 2022.

Analysis - Fee Schedule - Surgeon/Assistant - DOS 04/25/2022

In the present case, Applicant apparently billed Respondent in the aggregate amount of $8,038.14 under CPT Codes 29823-LT, 29825-59-LT, 29821-59-LT, and 29999-LT (2 units) for the surgeon services related to an arthroscopy of the left shoulder of the Assignor conducted on April 25, 2022 and in the aggregate amount of $860.08 under CPT Codes 29823-83-LT, 29825-59-83-LT, 29821-59-83-LT, and 29999-83-LT (2 units) for the assistant services related to an arthroscopy of the left shoulder of the Assignor conducted on April 25, 2022. The bills were received on May 12, 2022. There are no denials in the record for such bills, and Respondent concedes that some payment is due.

Regarding the specific amount of reimbursement, Respondent uploaded a fee schedule/coder affidavit, sworn to on September 5, 2022, by John L. Cerf, D.C., C.P.C, who asserts that the appropriate reimbursement for the surgeon and assistant services in this proceeding is $3,427.65.

Regarding CPT Code 29823, "Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid

bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])," Dr. Cerf notes that:

> The New York Workers' Compensation Medical Fee Schedule Surgery Ground Rule 5 states that, "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 of the lesser procedures.

Dr. Cerf finds that CPT code 29823 was the procedure with the highest allowance and pursuant to Ground Rule 5 was compensable at 100 percent of its reimbursement amount, or $2,065.91 [$251.94 x 8.20 RVU] when the appropriate surgery conversion factor is applied to the assigned RVU for CPT code 29823.

Regarding CPT Code 29999, "Unlisted procedure, arthroscopy," Dr. Cerf noted that Applicant used the unlisted arthroscopy procedure code to represent a subacromial bursectomy. He noted that the operative report documented that:

> There was excessive, hyperemic bursitis seen throughout the subacromial space; using the shaver an extensive bursectomy was performed removing the excessive hyperemic bursitis encountered.

Dr. Cerf asserted that Applicant incorrectly billed for both codes 29823 and 29999 as the CPT code 29823 definition includes extensive debridement of 3 or more discrete structures that includes the subacromial bursa. Because subacromial bursectomy is included in the CPT code 29823 definition, he found no additional reimbursement was due and that allowable reimbursement for CPT code 29999 (bursectomy) was $0.00

Dr. Cerf noted that Applicant also used CPT code 29999, "Unlisted procedure, arthroscopy," to represent a coracoacromial ligament release. He noted that the operative report documented that:

> Using the shaver, a lysis of the thickened CA ligament was performed preserving its medial attachments.

Dr. Cerf asserted that it was incorrect to represent CA ligament release with the unlisted arthroscopic procedure code 29999 because the extensive debridement, represented by CPT code 29823, includes removing damaged tissue, scar tissue, and adhesions in the front and back of the shoulder. He maintained that the extensive debridement code includes release of the CA ligament. As the procedure includes CA release without decompression, he contended that the proper representative code was the extensive debridement code, CPT code 29823. Dr. Cerf found there was no additional payment for CA ligament release since it was included in the extensive debridement procedure represented by code 29823. Thus, the allowable reimbursement for CPT code 29999 (CA ligament release) was $0.00.

Regarding CPT Code 29825, "Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation," Dr. Cerf again noted that Ground Rule 5

states that, "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 of the lesser procedures. He further noted that Ground Rule 5 goes on to instruct, "It is appropriate to designate multiple procedures that are rendered on the same date by separate entries. This can be reported by using the multiple procedure modifier 51." Applying the ground rule to the reimbursement for CPT Code 29825-51, he finds that the appropriate reimbursement for CPT Code 29825-51 was $1,030.43 [($251.94 x 8.18 RVU) x 50%].

Regarding CPT Code 29821, "Arthroscopy, shoulder, surgical; synovectomy, complete," Dr. Cerf asserted that such code should not have been billed for two reasons. First, the report does not use the words diseased or pathology to describe the synovium. Second, code 29821 is representing procedure that is included within CPT code 29823.

Dr. Cerf explained that The June 2013 American Medical Association CPT Assistant instructs, "Code 29821, Arthroscopy, shoulder, surgical; synovectomy, complete, is reported for a complete
synovectomy for a synovitic disease, such as rheumatoid arthritis or pigmented villonodular synovitis, with removal of the entire intra-articular synovium." He noted that the operative report documented that:

> There was extensive, inflamed hypertrophic synovitis seen throughout the glenohumeral joint; using the shaver an extensive synovectomy was performed removing the extensive inflamed hypertrophic synovitis encountered anteriorly and posteriorly.

Dr. Cerf noted that the operative report describes the synovium as "hypertrophic," i.e., enlarged, and "inflamed". He explained that Inflammation is defined as, "Cytologic and chemical reactions that occur in affected blood vessels and adjacent tissues in response to injury or abnormal stimulation from a physical, chemical, or biologic agent." He asserted that the words hypertrophic and inflamed describe normal physiological responses to trauma and are not, by themselves, descriptive of a disease process. He noted that the operative report did not document observing synovial disease, and no description of sending a diseased synovial sample to a pathology laboratory. Dr. Cerf asserted that the operative report does not provide documentation to satisfy the code 29821 requirement that the entire synovium was removed for a synovitic disease to justify billing with code 29821.

Dr. Cerf noted that additionally, by definition, a joint capsule is composed of an outer fibrous layer or membrane and an inner synovial layer or membrane, i.e., the synovial membrane is a component of the articular capsule. Dr. Cerf asserted that Applicant incorrectly billed for both codes 29823 and 29821 as the CPT code 29823 definition includes extensive debridement of 3 or more discrete structures that includes the articular capsule. He maintained that because debridement of the articular capsule is included in the CPT code 29823 definition and because the synovial membrane is a component of the articular capsule, synovectomy is included in CPT code 29823. He contended CPT code 29821, representing complete synovectomy would only be

compensable if performed in the absence of another procedure that includes synovectomy. For these reasons, Dr. Cerf asserted that the allowable reimbursement for CPT code 29821 was $0.00.

Regarding the Assistant services, Dr. Cerf noted that the New York Workers' Compensation Medical Fee Schedule instructs that, "When a physician assistant or nurse practitioner performs services for assistants at surgery, identify the services by adding modifier 83 to the usual procedure code." He further noted that the New York Workers' Compensation Medical Fee Schedule directs, "Services of a physician assistant or nurse practitioner are reimbursed at 10.7 percent of the listed value of the surgical code and payable to the employing physician." Applying these rules, he determined that the appropriate reimbursement for CPT code 29823-83 was $221.05; for CPT code 29825-83-51 was $110.26. The allowable reimbursement for CPT codes 29821-83 and 29999-83 (two units) were $0.00 for the reasons set forth above.

Respondent uploaded relevant portions of the fee schedule and the supporting authorities referenced by Dr. Cerf in further support of its fee schedule defenses.

I find that Dr. Cerf's affidavit is sufficient to make a prima facie showing that the amounts charged by Applicant were in excess of the fee schedule. Dr. Cerf provides a clear explanation of his interpretation of the fee schedule with citation to fee schedule authorities. As Respondent has met its initial burden to come forward with competent evidentiary proof to support its fee schedule defenses, the burden shifted to Applicant to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. *See, Cornell Medical, P.C. v. Mercury Casualty Co.*, 24 Misc. 3d 58, 884 N.Y.S.3d 558 (App. Term 2d, 11th &13th Dists. 2009).

At the hearing, Applicant's counsel maintained the Respondent failed to meet its burden. Counsel asserted that Dr. Cerf's affidavit was not credible or persuasive as the sources cited were not recognized authority or reliable. Counsel specifically asserted that Dr. Cerf's analysis of CPT code 29821 was illogical and improper, and that Applicant should be reimbursed as billed as the charges were appropriately reduced by the multiple procedure rule. Applicant, however, did not upload a coder affidavit or put in any other evidence to support a different fee calculation or to otherwise rebut Respondent's fee reductions. I also do not find Applicant's counsel's arguments at the hearing to be convincing, especially without any analysis, explanation or opinion by a coder, fee schedule expert or other recognized authority. Applicant had the opportunity to rebut Respondent's evidence, but elected not to submit any evidence to challenge Respondent's assertions and opinions. As I found Respondent's evidence to be sufficient to meet its prima facie case, the burden of persuasion shifted to Applicant. As Applicant has failed to meet its ultimate burden of persuasion, I find that the appropriate reimbursement for the surgeon and assistant services in this proceeding to be $3,427.65.

Accordingly, Applicant is entitled to reimbursement in the aggregate amount of **$3,427.65** for the surgeon and assistant services related to an arthroscopy of the left shoulder of the Assignor conducted on April 25, 2022.

Conclusion

For the reasons set forth herein, Applicant is awarded reimbursement in the total amount of $3,490,50 with attorney's fees, interest and the arbitration filing fee as set forth below. This decision is in full disposition of all claims for no-fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not specifically raised at the time of the hearing.

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**
	William L. King, M.D. P.C.	**03/28/22 - 04/25/22**	**$8,961.07**	**Awarded: $3,490.50**
Total			**$8,961.07**	**Awarded: $3,490.50**

B. The insurer shall also compute and pay the applicant interest set forth below. 06/15/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

For the services provided on 3/28/22, interest shall be computed from June 15, 2022, the AR-1 filing date, at the rate of 2% per month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

For the services provided on 4/25/22, interest shall be computed from June 11, 2022, thirty days from receipt of the bills, at the rate of 2% per month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

C. Attorney's Fees

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

Respondent shall pay the Applicant attorney's fees in accordance with 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 NY
SS :
County of Suffolk

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

04/14/2023
(Dated)

Kihyun Kim

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:
ade708773182c06bcdaf8886127c3b55

Electronically Signed

Your name: Kihyun Kim
Signed on: 04/14/2023