

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Glenmore Medical PC  
(Applicant)

- and -

Allstate Insurance Company  
(Respondent)

AAA Case No. 17-22-1265-2750

Applicant's File No. BT22-181101

Insurer's Claim File No. 0606453990  
2CC

NAIC No. 19232

**ARBITRATION AWARD**

I, Jennifer Frankola, 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: EIP

1. Hearing(s) held on 10/24/2023  
Declared closed by the arbitrator on 10/24/2023

S. Sciarotto from The Tadchiev Law Firm, P.C. participated virtually for the Applicant

M. Inguanti from Law Office Of Lawrence & Lawrence participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$4,450.70**, was AMENDED and permitted by the arbitrator at the oral hearing.

Amended to \$2163.75 as per Applicant's fee coder affidavit by N. Margaryan, CPC dated 10/13/21.

Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated to the following:

1. Prima facie.
2. The denial is timely.

3. The sole issue is related to the fee schedule.

4. The interest date is 9/7/22

### 3. Summary of Issues in Dispute

This arbitration arises out of medical treatment for the Eligible Injured Party (EIP) (AM) related to injuries sustained in a motor vehicle accident (MVA) that occurred on 10/31/20.

Applicant is seeking reimbursement for \$4,450.70 which was amended to \$2,163.75 as per the Applicant's fee coder affidavit by N. Margaryan, CPC dated 10/13/23 for knee arthroscopy surgery that occurred on 5/14/20.

The issue presented at the hearing is whether the claim was billed appropriately according to the fee schedule.

All other claims and defenses are hereby waived.

This case was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

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

#### **Fee Schedule**

Respondent must demonstrate by competent evidentiary proof that applicant's claims were in excess of the appropriate fee schedules, otherwise respondent's defense of noncompliance with the appropriate fee schedule cannot be sustained. Continental Medical, P.C. v. Travelers Indemnity Co., 11 Misc. 3d.145A, 819 N.Y.S.2d 847 (App. Term 1st Dept. 2006). I take judicial notice of the fee schedule.

#### **Respondent's Coder Affidavit**

Here, Respondent paid Applicant \$2718.13 and argues that nothing further is owed. The basis for this is based upon their coder affidavit by C. Mallory, CPC dated 6/30/22. AT the hearing, the parties agreed that the dispute was with respect to Codes 29876 and 29999. In Respondent's affidavit, Respondent indicated that for both of these codes the amount is \$0.00.

*Regarding Code 29876, Respondent states: there are only three components in the knee. Medial, lateral and patellar femoral. The provider has already reported that code 29880 which was performed in the medial and lateral component. So, it is not possible to have a two compartment synovectomy. Code 29875 is with respect to a knee Arthroscopy*

*surgery in a separate procedure. This would be for one compartment but it cannot be submitted with more expensive procedure. Respondents cited 2 CPT assistant from January 2016 volume 26, issue one. Code 29875, which describes limited synovectomy, it's for a separate procedure. This means that the work associated with this procedure is inclusive to more extensive procedures performed in the same anatomic site, the knee, and is not separately reportable if other arthroscopic knee procedure is performed on the same knee in the same session. This code should only be reported if it is the only procedure performed. Respondent concludes that a medial and lateral meniscectomy, 29880 supports the synovectomy of the medial and lateral components which is included in 29880. Therefore respondent assigned an amount of \$0.00.*

*Regarding code 29999, Respondent also assigned an amount of \$0.00. They say this is with respect to coblation arthroplasty and that this type of debridement is included in CPT code 29880. Respondent concludes that the proper amount is \$2718.13 which was paid to applicant.*

Upon review of the affidavit, I find that it meets Respondent's burden.

The burden shifts to Applicant.

### **Applicant's Coder Affidavit**

Applicant submits a fee coder affidavit by N. Margaryan, CPC dated 10/13/23 and claims that the proper amount owed is \$2,163.75.

Applicant's fee coder affidavit states the following:

*For CPT Code 29876: Ms. Mallory first claims that code 29875 should have been reported instead of code 29876. The Operative Report explains that a synovectomy was performed in three knee compartments, which supports the billing of code 29876. The description of code 29876 attached instructs that code 29876 is reportable for a synovectomy in two or more compartments. Thus, code 29876 was properly reported.*

*Ms. Mallory then claims that code 29876 cannot be reported with code 29880. However, according to the CPT Assistant, code 29876 is properly reported with another knee procedure, "even if it occurs in the same compartment," as long as a pathologic disease was present. Please see the article attached, which Ms. Mallory has previously cited. Here, the Operative Report describes the synovium as being "hypertrophic," thus warranting the synovectomy. Please see the attached Operative Report. Since synovitis is a synovial disease (inflammation of the synovium), and since there was synovitis, a complete synovectomy was properly performed and reported. Accordingly, code 29876 was properly reported pursuant to the NYS WCB Medical Fee Schedule, because a complete synovectomy was performed in three compartments as a result of pathologic synovitic disease.*

*Further, Ms. Mallory cited to and relies on the AAOS to support her reasoning that code 29876 was improperly reported. It is well settled that the AAOS is not an authoritative source for determining the proper fee schedule under the New York State Workers'*

*Compensation Board's Medical Fee Schedule. The AAOS has not been adopted or incorporated into the NY WCB Fee Schedule as, for example, the CPT Assistant has. Therefore, Ms. Mallory's reliance on the AAOS is misplaced. Accordingly, code 29876 is separately reimbursable for \$1,032.95.*

*Code 29999 is a "by report" code, which is utilized when there is no specific CPT code for the procedure performed. In this case, code 29999 was billed for a coblation arthroplasty as per the Operative Report.*

*Ground Rules 2 and 3 provide instructions as to how a by-report code such as code 29999 should be analyzed and reimbursed. Specifically, Ground Rule 3 states that the following information should be considered when analyzing a "by report" code: "the nature, extent, and need for the procedure or service, the time, the skill and equipment necessary, etc." The nature, extent, need, skill, and equipment for the service are all discussed in the attached letter from Dr. Daly. Dr. Daly also discusses that the complexity and skill used in performing a coblation arthroplasty may be reasonably compared to 29877 (arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (eg, medial or lateral)). CPT code 29877 has an RVU of 7.11, giving it a reimbursement rate of \$1,791.29 when multiplied by the Region IV Surgery Conversion Factor. However, Dr. Daly estimated the coblation arthroplasty to be reimbursed at a modestly higher rate of \$2,065.91 due to the added complexity compared to a chondroplasty. Please see the attached letter from Dr. Daly. However, because the multiple procedure reduction rule applies to CPT code 29999, it is reduced to \$1,032.95.*

*Without engaging in such an analysis, Ms. Mallory denies reimbursement for code 29999 by conclusively arguing that CPT code 29999 is a debridement and included in code 29880. However, she fails to note that debridement and coblation arthroplasty are completely different procedures, irrespective of the tools utilized. As such, it is inappropriate to include code 29999 in code 29880.*

*Furthermore, the CPT Assistant provides insight into reporting code 29877 (the code most similar to code 29999) with code 29880. It should be emphasized that while Dr. Daly established that code 29999 is most similar to code 29877 for purposes of determining an RVU, Dr. Daly did not state that a coblation arthroplasty is the same as a chondroplasty. In fact, the procedures are quite different, as explained in the letter from Dr. Daly. In any case, code 29877 may still be separately reimbursed with code 29880, which indicates that code 29999 may be separately reimbursed from code 29880 as well.*

*The CPT Assistant, which is published by the American Medical Association, explicitly states that code 29877 is separately reimbursable in addition to code 29881 if code 29877 is performed in a different anatomic site, e.g., articular cartilage of the femoral condyle. Please see the attached February 1996 CPT Assistant article. This point was further clarified by the AMA in a later CPT Assistant article, in which the AMA stated that code 29877 and code 29880/29881 can be separately reported and reimbursed when performed at the same session if the procedures are performed in separate compartments of the knee. Please see the attached June 1999 CPT Assistant article.*

*Also, please note that the June 1999 article states that the knee has three compartments: (1) medial, (2) lateral and (3) patellofemoral. This same point was reiterated in a third CPT Assistant article published in August 2001. Please see the attached August 2001 CPT Assistant article, stating that code 29877 can be reported with code 29880 if code 29877 is performed in a different compartment.*

*In this case, the Operative Report states that partial lateral and medial meniscectomies (code 29880) were performed in the lateral and medial compartments. However, a coblation arthroplasty of the patella was performed (code 29999) in the patellofemoral compartment. Accordingly, code 29999 was 4 performed in a different compartment than code 29880. Based on the AMA's CPT Assistant articles, code 29999 is separately reimbursable in addition to code 29880, because they were performed in different compartments.*

*Physician's assistants are reimbursed according to General Ground Rule 15. Modifier 83 is appended to indicate that the billed code was performed by a physician's assistant. General Ground Rule 15 states that when Modifier 83 is appended, the fee is 10.7% of the surgeon's fee.*

*For the same reasons aforementioned, codes 29876-83 and 29999-83 should be reimbursed according to General Ground Rule 15. Applying the 10.7% reduction results in a fee amount of \$110.53 for code 29876-83 and \$110.53 for code 29999-83.*

*Respondent concludes that based on the fee schedule calculations and the attached documents, the total fee schedule amount for the surgery services is \$5,296.27. Since the carrier has already paid the Applicant a sum of \$3,132.52, an outstanding balance of \$2,163.75 remains.*

Upon review of the affidavits in evidence and the arguments at hearing, I am most persuaded by Respondent's affidavit.

The claim is denied.

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 NY

SS :

County of New York

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

11/03/2023

(Dated)

Jennifer Frankola

**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:**  
1d6c50d35c752c9042d5e88f3c9816b2

### **Electronically Signed**

Your name: Jennifer Frankola  
Signed on: 11/03/2023