

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

CD Orthopedics, P.C. f/k/a Olympic  
Orthopedics P.C.  
(Applicant)

- and -

State Farm Mutual Automobile Insurance  
Company  
(Respondent)

AAA Case No.	17-23-1287-1098
Applicant's File No.	3119004
Insurer's Claim File No.	32-36X6-83S
NAIC No.	25178

**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 11/22/2023  
Declared closed by the arbitrator on 11/22/2023

Andrew J. Costella, Esq. from Law Offices of Andrew J. Costella Jr., Esq. participated virtually for the Applicant

Jasmine Cornett, Esq. from James F. Butler & Associates participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$11,066.02**, 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 additional reimbursement for the surgeon's and physician's assistant (PA) costs related to a right shoulder arthroscopic procedure provided to the IP (R.A. 46 year-old female) on November 1, 2022, relative to a June 19, 2022 motor vehicle accident. The sole issue before me concerns the rate of reimbursement for the services rendered. This matter is determined after reviewing the submissions and presentations of both sides. I have reviewed the documents contained in the electronic case folder as of the closing of the file. The hearing was held on Zoom.

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

**I find for the respondent and deny the claim in its entirety.**

#### **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 layperson is not qualified to evaluate the CPT codes or to change if a health provider in its bills uses the code. 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.

Notwithstanding, if an insurer presents sufficient evidence to substantiate its reduction of a bill pursuant to the Workers' Compensation Medical Fee Schedule, the burden shifts to the medical provider to rebut the carrier's fee schedule interpretation, see, Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc. 3d 132A (App Term 1st Dept. 2011).

#### **Submissions**

Initially, I note the applicant billed the same amount for the surgeon and the PA for each line item of the surgical procedure.

Specifically, the applicant billed CPT code 29822 arthroscopic shoulder debridement at \$1,730.00 and a second notation with Modifier 83 also at \$1,730.00; CPT code 29820, partial synovectomy with modifier 59 at \$1,630.00 and a second line item with modifier 59 and 83, again at \$1,630.00; CPT code 29825 arthroscopic shoulder resection with or without manipulation with modifier 59 at \$2,060.87 with a second line item billed with modifier 59 and 83 at \$2,060.87; and finally, CPT code 29999 unlisted procedure arthroscopy for specific arthroscopic thermal capsulorrhaphy modifier 59 at \$2,275.00 with a second lined item with modifier 59 and 83 at the same amount of \$2,275.00.

The total amount initially billed was \$15,391.74. The applicant acknowledged the carrier paid \$4,325.72 (\$3,907.60 for the surgeon and \$418.12 for the PA); however, they still seek the amended \$11,066.02.

Per the Surgery Ground Rules, modifier 83, the code utilized by the provider indicates a physician assistant or nurse practitioner as assistant surgeon and is entitled to reimbursement at only 10.7% of the surgical code. Please see also surgical ground rule 12(f).

Therefore, even if additional reimbursement was owed, the reimbursement for the physician's assistant is limited to 10.7% of the surgeon's bill.

Additionally, in support of the respondent's defense, they have provided an affidavit from Lori Ercolini, Certified Professional Code (CPC), attesting to her knowledge and credentials concerning the New York State Workers' Compensation Fee Schedule.

The affiant notes this procedure is performed in Region IV of New York, which allows conversion back for surgery at \$251.94. Concerning CPT code 29825, the highest allowance serviced, payment is 100 percent for the relative value units (RVU), which is 8.18 multiplied by the \$251.94 conversion factor (CF) equals \$2,060.87.

CPT code 29822 is subject to Surgery ground rule 5, which allows for payments at fifty percent of the fee. Therefore, noting the RVU of 7.55 multiplied by \$251.94 totals \$1,902.15, less fifty percent equals \$951.07.

Continuing, CPT code 29820 is subject to the same Surgery Ground Rule 5; therefore, computations allow for RVU of 7.11, multiplied by \$251.94, a total of \$1,791.29, less fifty percent equals \$895.65.

In terms of the item billed CPT code 29999, Ms. Ercolini states "[t]he documentation on the operative report for date of service 11/1/22 states an arthroscopy on the right shoulder was performed for debridement, a synovectomy, lysis of adhesions and a bursectomy. They are trying to bill for a bursectomy with code 29999. However, according to the AMA, they cannot bill code 29999 for a bursectomy separately from the debridement or code 29822. Therefore, codes 29999 and 29999-83 will be allowed at zero because they are included in codes 29822 and 29822-83."

Ms. Ercolini finds that proper reimbursement for the surgeon herein would be \$3,907.60 for CPT codes 29825, 29822, and 29820. CPT code 29999 is not properly reimbursed if the provider indicated the wrong procedure, which was not undertaken, noting the operative report.

In terms of the PA with modifier 83 noted, each of these items is reimbursable at 10.7 percent, allowing for \$220.51 for CPT code 29825, \$101.76 for CPT code 29822, and, finally, \$95.83 for CPT code 29820, totally \$418.11. Therefore, reimbursement was proper with a one cent overpayment.

The applicant has provided an affirmation from Dr. Christopher Durant, noting that he disagrees with any determinations by a coder who is not a medical physician and without understanding that a separate bursectomy is a surgical procedure derived from a controlled ablation and how it is performed. The affidavit and arguments set forth by the applicant's counsel indicated the carrier did not understand the procedure and should have requested further verification to better understand what occurred and therefore reimbursement at the proper rate.

Notwithstanding, it does not appear Dr. Durant's affirmation is case specific, noting he discusses CPT codes 29876, 29877 and 29870 (concerning a knee arthroscopy) which was not the procedure performed in this case. He discusses the applicability of Surgery ground rule 5, which was applied to the codes billed.

In terms of CPT code 29999, he states it was not unbundling as additional fees are owed and allowed due to multiple excisions and incisions made pursuant to the New York State Workers' Compensation Board fee schedule and the Enhanced Ambulatory Patient Groups (EAPG) framework. Again, the affirmation is not fact-specific to this claim.

**Under the circumstances, the claim is denied in its entirety.**

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 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.

12/05/2023  
(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:**  
16acfc600ec03c10fd65b6c6c389cad0

### Electronically Signed

Your name: Victor Moritz  
Signed on: 12/05/2023