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)	AAA Case No.	17-23-1287-1122
	Applicant's File No.	3119002
- and -	Insurer's Claim File No.	32-36X6-83S
	NAIC No.	25178
State Farm Mutual Automobile Insurance Company (Respondent)		

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

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

2. The amount claimed in the Arbitration Request, **$10,000.00**, 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's (PA) fees related to a left knee arthroscopic procedure provided to the IP (E.E.M. 56-year-old male) on, September 27, 2022, relative to a July 19, 2022 motor vehicle accident. The sole issue before me concerns the reimbursement rate for the services rendered. In support of the respondent position, the carrier has submitted a coding affidavit from Mercy Acuna, CPC. This matter is determined after reviewing the

submissions and the 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.

Submissions

The applicant billed the sum of $10,000.00 for a right knee arthroscopy, as follows: CPT Code 29870 arthroscopy, separate incision, at $1,095.00; CPT Code 29876- modifier 59- at $0.00; CPT code 29877- Chondroplasty, separate incision debridement at $1,630.00; CPT Code 29880- Meniscectomy, medial and lateral incision at $0.00; CPT Code 20610 - modifier 59- Aspiration of the injection, shoulder, hip, or knee at $0.00, and finally CPT Code 2999, arthroscopic thermal capsulorrhaphy - modifier 59- (shoulder (sic) at $2,0275.00).

The applicant's bill included a second listing of each of these items, with the additional modifier 83, however, billed at the exact same rate. The totality of the provider's bill was $10,000.00.

The respondent issued a partial denial, reimbursing the total sum of $3,944.23 and denying the remainder based on the fee schedule. In sum, CPT Code 29876, was reimbursed at $1,032.96, CPT Code 20610 was entitled to $31.50 and CPT Code 29880 at $2,475.00, for a total sum of $3539.46 for the surgeon. The respondent further noted that while the provider billed for the PA fee at the same rate, pursuant to the fee schedule, they were entitled to only 10.7 percent. Therefore, CPT Code 29876 with modifier 83, was entitled to $110.53, CPT Code 20610 was entitled to $3.37, and CPT Code 29880, was entitled to $290.87 for a total sum of $404.77 for the PA.

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).

In support of the respondent's position, they have provided a Coding Affidavit from Ms. Acuna, attesting to her knowledge and credentials. She is a certified professional coder and indicated the determination was based on her knowledge of the New York State Workers' Compensation Medical Fee Schedule, the CPT Assistant published by the American Medical Association, and other relevant items.

In this case, she notes that the provider was located in Region IV of New York, which has a conversion factor (CF) of $251.94.

CPT code 29880 has the highest allowance, therefore, payment is at 100% relative value units (RVU) = 10.79 x $251.94) = $2,718.43, however the provider billed the amount of $2,475.00.

CPT code 29876 is subject to the Surgery Ground Rules # 5; therefore, payment is at 50% of the fee allowance = (RVU = 8.20 x $251.94 = $2,065.91) at 50% = $1,032.96.

CPT code 29877-59 is considered to be inclusive with CPT code 29880 regardless in which compartment the chondroplasty is performed (therefore, the use of modifier 59 is not appropriate). This is based on the revised description of CPT code 29880 (revised as of January 2012). The description of CPT code 29880 includes chondroplasty: Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage(chondroplasty), same or separate compartment(s), when performed.

Also, per the CPT Book, under CPT code 29877 (when performed with arthroscopic meniscectomy, see 29880 or 29881) The use of the modifier 59 is not appropriate since all procedures were performed on the same knee, the right knee.

CPT code 29870 (diagnostic arthroscopy) is not separately reimbursable from CPT code 29880 and 29876. Per the CPT Book instruction: "Surgical endoscopy/arthroscopy always includes a diagnostic endoscopy/arthroscopy." The use of modifier 59 is not appropriate since all procedures were performed on the same knee, the right knee.

Per the AMA CPT Assistant August 2001 issue: When both a diagnostic and surgical arthroscopy are performed, the diagnostic arthroscopy is an inclusive component of the surgical arthroscopy and would not be reported separately. Per the CPT Manual Modifier 59 is Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. NOTE: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same day, see modifier 25.

CPT code 20610 (injection major joint/bursa) is included in the intraoperative global surgical package therefore not reimbursed separately.

Per the AMA CPT Assistant: *Code 20610, Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa), should not be reported when performed concurrent with another intra-articular procedure (eg, knee arthroscopy). However, should the bupivacaine injection be performed at an anatomic site other than that of the knee arthroscopy, then the appropriate code from the 20600-20610 series should be reported, as appropriate, with modifier 59, Distinct procedural service, appended. ï· The use of the modifier 59 is not appropriate in this case since the injection was administered immediately after the arthroscopic procedure on the same knee.*

CPT code 29999 is in the Surgery section therefore the two applicable rules are the following: Per NY WC Medical Fee Schedule, General Ground Rules #3: Procedures listed without Specified Unit Values, By report (BR) items: "BR" in the relative value column represents services that are too variable in the nature of their performance to permit assignment of unit values. Fees for each procedure need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished… for any procedure where the unit value is listed in the schedule as "BR", the physician shall establish a unit value consistent in relativity with other unit values shown in the schedule. The insurer shall review all submitted "BR" unit value to ensure that the relativity consistency is maintained…" Per NY WC Medical Fee Schedule, Surgery

Ground Rules #10: By report (BR) items: "BR" in the relative value column indicates that the value of this service is to be determined "by report" because the service is too unusual or variable to be assigned a relative value. Information concering the nature, extent and need for the procedure or service, time, skill and equipment necessary, etc., is to be furnished…

The provider is billing CPT code 29999 for "coblation arthroplasty" of the patellar compartment. The term arthroplasty per the medical dictionary is "surgery to relieve pain and restore range of motion by realigning or reconstructing a joint"). The procedure performed was chondroplasty using a "coblation" device which is a tool or method in performing chondroplasty…

Chondroplasty is included in CPT code 29880 by definition "Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty) same, or separate compartment(s), when performed." The use of the "wand" as opposed to or in addition to the "shaver" does not make the service/procedure separately reimbursable from the more extensive procedure (29880). Per the NY Worker's Compensation Surgery Ground Rule # 1B:… The allowable amount for CPT code 29999 = $0.

The total allowable amount for the primary surgeon per fee schedule = $3,507.96.

Additionally, the affiant continues that, for the physician's assistant, pursuant to New York State Workers' Compensation Medical Fee Schedule Surgery Ground Rule Number 12, Subsection F, reimbursement is limited to 10.7 percent; therefore, utilizing the same calculations at 10.7% allows for reimbursement totaling $401.40.,

Accordingly, in this case, the respondent was owed the sum of $3,909.36, and the respondent paid the amount of $3,944.23; therefore, no additional amounts are owed.

In this instance, the applicant's counsel argued that the respondent's coder lacked the expertise to determine the actual medical procedures undertaken and, therefore, what coding should be implemented. At a minimum, the carrier should have retained a medical expert to review the procedure and billing. The applicant acknowledged the provider did not offer a competing expert affidavit or other evidence related to the fee schedule amount owed for the service rendered.

Conclusion

I accept the analysis the respondent's expert, Ms. Acuna set forth. She is a certified professional coder and provides simple direct computations for each item undertaken herein. The fee schedule determinations made by this expert appear proper, and in this instance, there is no contradictory evidence from the provider to refute the determinations of the carrier's expert.

Therefore, I find the provider was properly reimbursed at (or in this case) above the fee schedule and 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.

12/08/2023
(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:
8bde12b3154127051aa1f1e5ccc72fea

Electronically Signed

Your name: Victor Moritz
Signed on: 12/08/2023