

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Advanced Orthopedics & Joint Preservation PC (Applicant)	AAA Case No.	17-23-1296-2522
	Applicant's File No.	SS-244393
	Insurer's Claim File No.	0674622971-01
- and -	NAIC No.	29688

Allstate Fire & Casualty Insurance Company
(Respondent)

ARBITRATION AWARD

I, Michael Resko, 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: Claimant

1. Hearing(s) held on 12/13/2023
Declared closed by the arbitrator on 12/13/2023

Gregory Itingen Esq. from Samandarov & Associates, P.C. participated virtually for the Applicant

Marina Sechenova Esq. from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$5,269.96**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant's counsel amended the total amount in dispute to **\$2,052.15**.

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

The parties stipulated and agreed that (i) Applicant has met its *prima facie* burden by submitting evidence that payment of no-fault benefits is overdue, and proof of its claim was mailed to and received by Respondent; and (ii) Respondent's denials of the subject claims were timely issued.

3. Summary of Issues in Dispute

The EIP/Assignor is referred to herein as Claimant. Claimant is a 45-year-old female driver injured in a motor vehicle accident on 06/15/22.

Applicant seeks payment of the balances of claims for the primary surgeon and physician's assistant (PA) who performed a left shoulder arthroscopic surgery on date of service 10/13/22.

Respondent partially paid both claims.

Both parties have submitted coder's affidavits in support of their arguments regarding the correct reimbursement due for the subject claims.

Respondent has also submitted evidence that its policy limits were "nearing exhaustion" as of the hearing date, but the amount remaining on the policy was greater than the amended amount in dispute.

The following evidence was submitted, reviewed, and considered: All documents contained in the ADR Center as of the date the hearing was declared closed.

4. Findings, Conclusions, and Basis Therefor

The surgical services at issue in this case were performed at an ambulatory surgery center in New Jersey. Pursuant to 11NYCRR 68.6(b): Except as provided in subdivision (a) of this section, if a professional health service reimbursable under Insurance Law section 5102(a)(1) is performed outside this State with respect to an eligible injured person that is a resident of this State, the amount that the insurer shall reimburse for the service shall be the lowest of: (1) the amount of the fee set forth in the region of this State that has the highest applicable amount in the fee schedule for that service; (2) the amount charged by the provider; and (3) the prevailing fee in the geographic location of the provider. (c) If the jurisdiction in which the treatment is being rendered has established a fee schedule for reimbursing health services rendered in connection with claims for motor vehicle-related injuries and the fee schedule applies to the service being provided, the prevailing fee amount specified in subdivisions (a) and (b) of this section shall be the amount prescribed in that jurisdiction's fee schedule for the respective service."

The table below sets forth the CPT codes and amounts claimed on Applicant's bill(s), and the amounts paid by Respondent:

CPT code	Amount billed - surgeon	Amount paid - surgeon	Amount billed - PA	Amount paid - PA

29823 LT	2065.91	2065.91	227.25	221.05
29825 LT 59	2060.87	1030.44	226.70	110.26
29821 LT 51	1957.57	0	215.33	0
29826 LT 51	496.32	496.32	54.60	53.11
29999 LT 59	1750	0	192.50	0

The parties agree the only codes in dispute are 29821 and 29999.

Respondent's coder (Jeffrey Futoran, CPC) performed analyses and calculated reimbursement for both the primary surgeon and PA's bills in New Jersey and New York. Mr. Futoran wrote as follows, relevant parts:

¶ NCCI Edits state CPT codes 29821 and 29825 may not be reported together with CPT 29823 unless an applicable modifier is used to bypass the coding edit.

¶ Provider appended modifiers 59 (separate procedure) to 29825 and 29999.

¶ Modifier 59 is used by NCCI and permits reimbursement subject to its proper use as defined by CMS Modifier 59 Article: Proper Usage Regarding Distinct Procedural Service. See N.J.A.C 11:3-29.4(g).

¶ Modifier 59 Article states: Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass a procedure to procedure (PTP) edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used. Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ. . . .

¶ Assignee submitted an operative report documenting all procedures were performed on the right shoulder.

¶ Per Modifier 59 Article, Assignee's use of modifier 59 with CPT 29825 and 29999 is improper as the services were performed in the same anatomic site (left shoulder) as services billed under CPT 29823, 29825, 29821, 29826 and 29999.

¶ N.J.A.C. § 11:3-29.4 incorporates by reference the NCCI Policy Manual for Medicare Services and instructs its use when interpreting fees.

¶ NCCI Policy Manual Chapter IV, Section E, paragraph 4 and 7 states: 4. CMS considers the shoulder to be a single anatomic structure. With three exceptions an NCCI procedure-to-procedure edit code pair consisting of two codes describing two shoulder arthroscopy procedures shall not be bypassed with an NCCI-associated modifier when the two procedures are performed on the ipsilateral shoulder. This type of edit may be bypassed with an NCCI-associated modifier only if the two procedures are performed on contralateral shoulders. The three exceptions are described in Chapter IV, Section E (Arthroscopy), Subsection #7. 7. Shoulder arthroscopy procedures include limited debridement (e.g., CPT code 29822) even if the limited debridement is performed in a different area of the same shoulder than the other procedure. With three exceptions, shoulder arthroscopy procedures include extensive debridement (e.g., CPT code 29823) even if the extensive debridement is performed in a different area of the same shoulder than the other procedure. CPT codes 29824 (arthroscopic claviclectomy including distal articular surface), 29827 (arthroscopic rotator cuff repair), and 29828 (biceps tenodesis) may be reported separately with CPT code 29823 if the extensive debridement is performed in a different area of the same shoulder.

¶ The above NCCI instructions state (1) the CMS considers the shoulder a single anatomic structure and (2) shoulder NCCI edits may not be bypassed unless exceptions stated in paragraph 7 are met.

Regarding code 29999, Mr. Futoran conducted a thorough review of Applicant's operative report and concluded, in relevant parts:

¶ Assignee reports CPT 29999 (unlisted procedure arthroscopy) with a charge of \$1,750.00 for a bursectomy (cutting of bursa tissue).

¶ Assignee's operative report documents a bursectomy (cutting/removal of bursa tissue) in the subacromial compartment of the shoulder.

¶ The above instructions require interpretation of the fee schedule in accordance of the AMA CPT Assistant.

¶ The AMA CPT Assistant April 2012 publication states: Frequently Asked Questions: Surgery: Musculoskeletal Question: What CPT code(s) may be reported in the event arthroscopic subacromial decompression with partial acromioplasty is performed independent of any other arthroscopic shoulder procedure(s)? Answer: Code 29822, Arthroscopy, shoulder, surgical; debridement, limited, or code 29823, Arthroscopy, shoulder, surgical; debridement, extensive, may be reported as appropriate when a subacromial decompression is done by itself. For

example, if a subacromial decompression is performed alone, which usually involves debridement of soft tissue and bone removal, then code 29822 may be reported. If debridement of bone and soft tissue is performed, this code is correct and accurately describes the work done. If there is extensive work done in the removal of the soft tissue and bone, then one would report 29823.

¶ Per the AMA CPT Assistant, the documented procedures documented by Assignee are reported under CPT 29823 for the extensive cutting of tissue and bone throughout the shoulder joint (ie labrum and subacromial joint space).

¶ Therefore, Assignee may not report the cutting of bursa tissue under CPT 29999.

Mr. Futoran calculated the total reimbursement for both claims using the NJ PIP fee schedule was \$2,977.80. He calculated the total reimbursement using the NY Workers' Compensation fee schedule to be \$5,060.61 and reached his ultimate conclusions:

¶ Per 11 NYCRR 68.6(b), the out of state health service is reimbursed \$2,997.80 as it is the lowest of the 68.6(b)(1), (2) and (3) amounts.

¶ To date, Assignee received \$3,977.09 towards the \$2,997.80 fee documenting an overpayment of \$979.29 . No additional payment is owed.

It is Respondent's initial burden to come forward with competent evidentiary proof to support its fee schedule defense. *Continental Medical PC v. Travelers Indemnity Co.*, 11 Misc.3d 145A, 819 N.Y.S.2d 847, (App. Term, 1st Dept. 2006). Mr. Futoran's affidavit is sufficient to satisfy Respondent's burden.

Applicant has submitted the affirmation of Aaron J. Perretta, Esq., CPC "in opposition to Respondent's EOBs & Jeffrey Futoran's Fee Affidavit". Mr. Perretta took exception to Mr. Futoran's methodology as contrary to what is required by 11 NYCRR § 68.6(b). According to Mr. Perretta:

¶ The method mandated for computing the lowest reimbursement rate in this particular instance is simple: One first applies the New York State Workers' Compensation Medical Fee Schedule (hereinafter "NY Fee Schedule") to the Codes listed on the bills, and generate a total value. We then apply the New Jersey Fee Schedule, Physicians' Fees North (hereinafter "NJ Fee Schedule") separately to the Codes listed on the bill, thereby generating a second total value. Finally, we compare the two total values generated by the NY and NJ Fee Schedules, and ultimately utilize the lesser total value generated by the two fee schedules.

¶ And Applicant would argue Respondent previously adopted the NY Fee Schedule in regards to these codes, as it reimbursed Codes 29823, 29825 and 29826 at their correct NY Fee Schedule amounts for the surgeon and PA.

¶ However, in this matter, Futoran never independently applies the NJ Fee Schedule separately to the codes billed. Instead, Futoran applies the NJ Fee Schedule to the codes as billed - meaning, codes that were already coded and billed pursuant to the NY Fee Schedule - and improperly limits the NJ Fee Schedule reimbursement rates by the listed billed amounts valued at the NY Fee Schedule rates (to be discussed at length infra).

Mr. Perretta then calculated the total reimbursement for both bills using the NY Workers' Compensation fee schedule as \$6,029.24, which includes payment for codes 29821 and 29999 both of which Mr. Futoran concluded should not be reimbursed at all.

Mr. Perretta then calculated the NJ reimbursement at \$8,284.99. I am convinced by Mr. Perretta's argument that Mr. Futoran incorrectly calculated the correct reimbursement of these claims under the NJ fee schedule and that it is correct to apply the NY Workers' Compensation fee schedule reimbursement amounts as the lesser of the 2 values. The issue remains, however, as to the codes 29821 and 29999.

Mr. Perretta wrote the following regarding code 29821:

¶ Please further note: while Respondent only reimburses Codes 29823, 29825 and 29826 per the NY Fee Schedule, Futoran concurs these three codes AND Code 29821 are entitled to reimbursement pursuant to the NY Fee Schedule. As such, Futoran's admission acts as Respondent's concession Applicant would indeed be entitled to reimbursement to Code 29821 per the NY Fee Schedule.

As for code 29999 - a "by report" code - Mr. Perretta began:

· REGARDING BY REPORT CODE 29999 & THE ACT OF DOWNCODING

- Futoran Offers Mere Lay Person Musings Concerning Her Downcoding By Report Code 29999 as Inclusive of Code 29823, Despite Respondent Never Submitting Futoran as a Medical Expert*
- Futoran is the Wrong Legal Vehicle by Which to Prove a Bursectomy is Included in a Debridement*
- Respondent Fails to Submit a Peer Doctor Affirmation Regarding Services Provided*

¶ First, Futoran argues Code 29999 should be down-coded to 29823, arguing the bursectomy process Code 29999 represents are better

represented - and included - by those services Code 29823 represents. Futoran bases his arguments solely upon his lay person interpretation of the operative report against a portion of the CPT Assistant. See Futoran Fee Affidavit, ¶¶ 41-50.

Upon review, Mr. Futoran included in his affidavit relevant portions of Applicant's own operative report, and in his analysis of code 29999 he included the following excerpt from the operative report (**emphasis added**):

Examination of the subacromial space revealed the following.

*Left shoulder traumatic subacromial impingement. Visualization of the subacromial space was difficult due to excessive bursitis **and a bursectomy was performed** using a combination of the radiofrequency device as well as a full-radius motorized shaver.*

At this point, the coracoacromial ligament as released with the radiofrequency device and the acromial branch of the thoracoacromial artery was coagulated with the same instrument.

The subacromial space was then irrigated with 300 ml of sterile saline and portal closure was then accomplished utilizing 3-0 Nylon sutures. This meticulous and time-consuming plastic surgery closure was performed to minimize postoperative scarring. Steri-Strips were applied with Mastisol to the portals, after which a sterile dressing was applied consisting of Adaptic gauze. 4 x 4's. and 2 ABDs. and a 6-inch Ace Bandage. The respective sponge and needle counts were correct at the end of the procedure and all instruments were inspected and found to be free of any damage.

Mr. Perretta's arguments to the contrary notwithstanding, it is not a matter of interpretation or medical expert opinion that a bursectomy was performed - Applicant's operative report states explicitly and unequivocally "**a bursectomy was performed** using a combination of the radiofrequency device as well as a full-radius motorized shaver."

I disagree with Mr. Perretta that Mr. Futoran is not qualified or the "wrong legal vehicle by which to prove a bursectomy is included in a debridement". It is firmly and clearly within the scope of a CPC - in fact it is the definition of the job - to review a medical record and determine if the services described therein "fit" into a particular CPT code's definition.

I further disagree with Mr. Perretta and find Mr. Futroran's conclusion that "Per the AMA CPT Assistant, the documented procedures documented by Assignee are reported under CPT 29823 for the extensive cutting of tissue and bone throughout the shoulder joint (ie labrum and subacromial joint space)" is supported by the section(s) of the AMA CPT Assistant cited in his affidavit.

Based on the evidence before me, Applicant is entitled to reimbursement for code 29821 but not 29999. This Award is in full disposition of all claims and issues before me in this proceeding.

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	Amount Amended	Status
	Advanced Orthopedics & Joint Preservation PC	10/13/22 - 10/13/22	\$4,738.00	\$1,853.79	Awarded: \$978.79
	Advanced Orthopedics & Joint Preservation PC	10/13/22 - 10/13/22	\$531.96	\$198.36	Awarded: \$104.73
Total			\$5,269.96		Awarded: \$1,083.52

- B. The insurer shall also compute and pay the applicant interest set forth below. 04/21/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Pursuant to the Court of Appeals decision in LMK Psychological Services P.C. v. State Farm, 12 N.Y.3d 217, 879 N.Y.S.2d 14 (2009), interest is tolled until the filing date where the Applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations" (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

The insurer shall pay the applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(e).

- 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 Westchester

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

12/22/2023
(Dated)

Michael Resko

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:
c37f4aa797172ffbaca3a2d2329691f2

Electronically Signed

Your name: Michael Resko
Signed on: 12/22/2023