

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Anarafena Medical PLLC
(Applicant)

- and -

State Farm Mutual Automobile Insurance
Company
(Respondent)

AAA Case No. 17-23-1291-5404

Applicant's File No. 130382

Insurer's Claim File No. 32-39T1-15T

NAIC No. 25178

ARBITRATION AWARD

I, Frank Marotta, 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: Assignor-DP

1. Hearing(s) held on 12/19/2023
Declared closed by the arbitrator on 12/19/2023

John Faris, Esq. from Law Offices of Eitan Dagan 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, **\$2,168.52**, was AMENDED and permitted by the arbitrator at the oral hearing.

The Applicant amended the amount in dispute to \$1,076.38.

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

The parties stipulate and agree that the sole issue is whether the Applicant is entitled to additional fees for their services.

3. Summary of Issues in Dispute

The record reveals that the Assignor-DP, a 23-year-old-male, sustained injuries in a motor vehicle accident on 9/28/22.

The Applicant seeks reimbursement for the balance of its fees in connection with a 12/1/22 office visit and left shoulder surgery performed by Dr. Christopher Durant and assisted by Boris Glukhovskiy, PA on 1/10/23.

The Respondent reimbursed the Applicant reduced amounts based on the New York State Workers' Compensation Fee Schedule (WCFS) for the services provided.

The issue is whether the Respondent properly reimbursed the Applicant for the services.

4. Findings, Conclusions, and Basis Therefor

The Applicant filed this arbitration in the amount of \$2,168.52, amended to \$1,076.38, for disputed fees in connection with an office visit on 12/1/22 and left shoulder surgery on 1/10/23.

This hearing was conducted using the documents contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association. All documents contained in the ECF are made part of the record of this hearing and my decision was made after a review of all relevant documents found in the ECF as well as the arguments presented by the parties during the hearing. In accordance with 11 NYCRR 65-4.5(o) (1), an arbitrator shall be the judge of the relevance and materiality of the evidence and strict conformity of the legal rules of evidence shall not be necessary. Further, the arbitrator may question or examine any witnesses and independently raise any issue that Arbitrator deems relevant to making an award that is consistent with the Insurance Law and the Department Regulations. The parties appeared and the hearing was conducted virtually via zoom.

DOS: 12/1/22

The Applicant submitted a bill in the amount of \$314.29 for an office visit and pulse oximetry for oxygen saturation on 12/1/22. The Applicant billed \$274.99 for the office visit using CPT code 99205 and \$39.30 for the pulse oximetry billed using CPT code 94760.

The Respondent reimbursed the Applicant \$220.00 for the office visit and \$31.44 for the pulse oximetry. The Respondent reimbursed the Applicant the reduced amount noting that *"For services performed by a Physician Assistant or a Nurse Practitioner the fee schedule amount is calculated at 80% of the fee available to physicians for such treatment code. (New York Workers' Compensation Medical Fee Schedule, Ground Rule 11)."*

At the hearing the Respondent refers to their fee schedule Affidavit of Jennifer Comunale, CPC from Signet Claim Solutions, LLC and concedes that the Applicant is owed an additional \$23.55 for the billed services on 12/1/22. According to Ms. Comunale the amount due for the office visit is \$275.00, therefore the Applicant should have been reimbursed the billed amount of \$274.99, but reimbursed should have been made for the pulse oximetry as CPT code 94760 is not to be billed in conjunction with an Evaluation and Management CPT code on the same date of service. The Applicant is entitled to the difference between what the Applicant is entitled to receive (\$274.99) and what was already paid (\$251.44) or \$23.55.

DOS: 1/10/23

The Applicant submitted a bill in the amount of \$4,998.48 for the services of Dr. Durant in connection with the left shoulder surgery. The Applicant billed \$2,065.90 using CPT code 29823 (Arthroscopy, shoulder, surgical; debridement, extensive...); \$1,030.44 using CPT code 29825 (Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation) and \$1,902.14 using CPT code 29999 (Unlisted procedure, arthroscopy).

The Respondent reimbursed the Applicant for CPT codes 29823 and 29825 as billed (\$3,096.34) but denied CPT code 29999 noting "*Bill is rated correct, note line 3 Line 3 - CPT 29999 = \$0 - Included in CPT 29823 - Line 1 Provider is reporting CPT Code 29999 for the bursectomy. The bursectomy is part of a subacromial decompression which was performed without an acromioplasty. Based on the provider's documentation, the appropriate code to report the bursectomy is CPT Code 29823 which was reported on line 1. REF: Knowledge Base #6105 - June 16, 2015.*"

The Applicant also submitted a bill in the amount of \$534.84 for the services of the physician assistant in connection with the left shoulder surgery. The Applicant billed \$221.05 using CPT code 29823 (Arthroscopy, shoulder, surgical; debridement, extensive...); \$110.26 using CPT code 29825 (Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation) and \$203.53 using CPT code 29999 (Unlisted procedure, arthroscopy).

The Respondent reimbursed the Applicant for CPT codes 29823 and 29825 as billed (\$331.31) but denied CPT code 29999 noting "*Bill is rated correct, note line 3 Line 3 - CPT 29999 = \$0 - Included in CPT 29823 - Line 1 Provider is reporting CPT Code 29999 for the bursectomy. The bursectomy is part of a subacromial decompression which was performed without an acromioplasty. Based on the provider's documentation, the appropriate code to report the bursectomy is CPT Code 29823 which was reported on line 1. REF: Knowledge Base #6105 - June 16, 2015.*"

The Applicant acknowledges the reimbursement for the services of the surgeon and physician assistant on their AR 1 form and amended the amount in dispute to \$1,052.83, \$951.07 for the services of Dr. Durant and \$101.76 for the services of Boris Glukhovskiy, PA. The Applicant amended their billing to reflect a 50% reduction of the charges in accordance with the Surgical Ground Rule for multiple procedures performed on the same day.

In support of their denial of the services billed using CPT code 29999 the Respondent relies on the fee Affidavit of Jennifer Comunale who notes that per the NY Workers' Compensation Medical Fee Schedule, Introduction and General Guidelines (paragraph 5) "this edition of the Official New York Workers' Compensation Fee Schedule uses CPT procedure codes, modifiers, and descriptions and, where appropriate the American Society of Anesthesiologist's Relative Value Guide. Please refer to the CPT Book for an explanation of coding rules and regulations not listed in this schedule." Ms. Comunale goes on to say that according to the CPT Book, 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])) include bursectomy. The provider has incorrectly appended CPT code 29999 to represent the bursectomy. Bursectomy is inclusive to CPT code 29823, therefore reimbursement is \$0.00.

The Applicant submits a comparison letter from the billing department noting CPT Code 29999 was billed because there is no other code which best describes the work performed. CPT Code 29822 was used as a "comparison code" for the extensive bursectomy performed within the Subacromial Bursal Space, which was documented on page 2 of the report. It is noted that the extensive bursectomy depicted on the operative report represents the complete removal specifically of the bursa encountered within the subacromial space not a portion, which is similar to the work represented by a limited debridement which is used for minor debridement of distinct structures or portions.

After a review of the documents contained in the ECF and in consideration of the arguments made by the parties at the hearing, I find for the Respondent. The Respondent provides a fee schedule assessment by a certified coder noting that a bursectomy performed per the comparison letter should not be billed separately as the procedure is inclusive in that performed and billed under CPT code 29823. I find that the Respondent's has provided prima facie proof in support of its burden showing that the Applicant's billing was not in accordance with the applicable fee schedule. Viviane Etienne Med. Care, P.C. v. Country-Wide Ins. Co., 2013 NY Slip Op. 50199(U) (App. Term 2d, 11th and 13th Jud Dist 2013), citing to Rogy Med., P.C. v Mercury Cas. Co., 23 Misc 3d 132 (A), 2009 NY Slip Op 50732 (U) (App Term, 2d, 11th & 13th Jud Dists 2009). In the absence of any proof by the Applicant supporting a contrary interpretation, Cornell Medical, P.C. v. Mercury Casualty Co., 24 Misc.3d 58, 2009 N.Y. Slip Op. 29228 (App. Term 2d, 11th and 13th Jud. Dists. 2009), I am persuaded by the Respondent's argument and find their denial of services billed using CPT code 29999 to be proper. Applicant's claim for additional fees for the surgeon and physician assistant is denied.

CONCLUSION:

For the reasons noted the Applicant is awarded \$23.55.

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
	Anarafena Medical PLLC	12/01/22 - 01/10/23	\$2,168.52	\$1,076.38	Awarded: \$23.55
Total			\$2,168.52		Awarded: \$23.55

- B. The insurer shall also compute and pay the applicant interest set forth below. 03/21/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The Respondent shall pay interest at a rate of 2% per month, calculated on a pro rata basis using 30-day month and in compliance with 11 NYCRR §65-3.9. Interest shall begin to accrue from the date of filing with the American Arbitration Association and end on the date the award is paid.

C. Attorney's Fees

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

The insurer shall also pay the applicant for attorney's fees as set forth below Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or the court, subject to a maximum fee of \$850." Id. The minimum attorney fee that shall be awarded is \$60. 11 NYCRR §65-4.5(c). However, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR §65-4.6 (i). For claims that fall under the Sixth Amendment to the regulation the following shall apply: "If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved disputes, subject to a maximum fee of \$1,360." 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, Frank Marotta, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

01/01/2024
(Dated)

Frank Marotta

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:
dbce2ae5cf29eef4b045bad731fded2f

Electronically Signed

Your name: Frank Marotta
Signed on: 01/01/2024