American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Cross Bay Orthopedic Surgery PC (Applicant)	AAA Case No.	17-23-1298-3982
	Applicant's File No.	BT22-213465
- and -	Insurer's Claim File No.	32-37Z1-83W
	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 07/15/2024
   Declared closed by the arbitrator on 07/15/2024

   James DiCarlo, Esq. from The Tadchiev Law Firm, P.C. participated virtually for the Applicant

   Jason Egielski, Esq. from Sarah C. Varghese & Associates f/k/a James F. Butler & Associates participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$7,139.75**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The applicant amended their claim to $2088.91

   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 costs associated with left shoulder arthroscopy provided to the IP (M.G., 68-old male) on December 17, 2022, relative to an August 11, 2022 motor vehicle accident. The sole issue before me concerns the reimbursement rate for the surgeon and physician's assistant (PA). In support of the

respondent's position, they have provided a coding analysis by Mercy Acuna CPC dated August 24, 2023. The applicant provided a coding analysis by Naira Margaryan CPC dated July 2, 2024, and a letter by Dr. Peter Tomasello D.O., the surgeon who performed the procedure, explaining the billing analysis. The applicant has amended their claim acknowledging some items were properly reimbursed, however, a dispute remains 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 applicant and award $983.12, representing the additional amount owed to the surgeon ($888.09) and PA ($95.03).

Underlying Claim

The applicant's claim concerns both the surgeon's and PA's services for a left shoulder arthroscopy that was performed per CPT Codes 29821 (arthroscopic shoulder surgical synovectomy complete); CPT Code 29823 (arthroscopic shoulder surgery debridement, extensive); CPT Code 29824 (arthroscopic shoulder surgical distal claviculectomy - Mumford procedure); CPT Code 29825 (arthroscopic lysis/resection of adhesions); CPT Code 29826 (arthroscopic shoulder surgical subacromial decompression); CPT Code 29827 (arthroscopic shoulder rotator cuff repair); and CPT Code 29999 (bursectomy of shoulder).

The respondent reimbursed the surgeon the sum of $5,552.43, and the PA totaled $594.13.

As stated above, the parties acknowledged the items at issue with CPT Code 29821 synovectomy and CPT Code 29999 bursectomy at the hearing.

Fee Schedule

The defendant has the burden of coming 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's bills use 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, I note Ms. Acuna's coding analysis, which discussed her knowledge and credentials. Ms. Acuna also discusses the various sources used to establish proper B schedule reimbursement, which includes the *New York State Workers' Compensation Medical Fee Schedule* and various other sources, including the *CPT Assistant*.

Both sides note that CPT Code 29827 would allow reimbursement at $2,348.08; however, the provider only billed and was reimbursed $2,325.41.

Regarding CPT Code 29821 synovectomy, Ms. Acuna notes, per the *April 2006 American Academy of Orthopedic Surgeons (AAOS)* guidelines, a complete synovectomy is for synovitic disease, giving examples would be removing the entire intraarticular synovium. This basis is supported by the *CPT Assistant*.

Ms. Acuna also notes that nothing in the CPT distinguishes between a synovectomy and a debridement, although there are codes for both. It is suggested the debridement be reserved for situations in which articulate cartilage is debrided and the synovectomy be used when only the soft tissue is removed. A partial synovectomy or a limited debridement would consist of work done in just a portion of the shoulder. To support a complete synovectomy or an extensive debridement, the documentation does not establish a complete debridement.

Regarding CPT Code 29999 for the bursectomy, again citing the *AMA CPT Assistant (May 2001*), the partial acromioplasty arch decompression excision of bursal tissue and release of the coracoacromial ligament would not be reported separately. As such, the provider was properly billed and was properly reimbursed for this procedure through CPT Code 29826, and it was inappropriate to bill additionally for the bursectomy under CPT Code 29999.

In opposition, I note the affidavit from Ms. Margaryan also discussing her knowledge and credentials.

Concerning CPT Code 29821, the AAOS is not considered authoritative concerning the *New York State Workers Compensation Medical Fee Schedule.*

Further, the *CPT Assistant* discussing a complete synovectomy for the synovitic disease is not a complete list of the basis to perform this procedure who indicates that synovitis is a synovial disease and the operative report provides the information necessary to meet the standards requirements for billing a complete synovectomy.

Ms. Margaryan also states, "An August 2021 CPT Assistant article states that a synovectomy, including debridement of synovitis, should be reported as a synovectomy. While the article specifies the knee, and while the shoulder is presently at issue, the CPT Assistant article captures the fact that a procedure addressing synovitis should be reported as a synovectomy. Since Dr. Tomasello cleared the diseased synovium and performed the synovectomy, code 29821 is also reimbursable pursuant to the August 2021 CPT Assistant article."

Concerning the bursectomy billed under CPT Code 29999, she notes, "Code 29999 should be analyzed as a "by report" code under Ground Rules 2 and 3. 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 attached letter from Dr. Tomasello discusses the nature, extent, need, skill, and equipment for the service. Dr. Tomasello also discusses that the complexity and skill used in performing a bursectomy may be reasonably compared to 29825 (lysis and resection of adhesions). CPT Code 29825 has an RVU of 8.18, giving it a reimbursement rate of $2,060.87 when multiplied by the Region IV Surgery Conversion Factor. However, Dr. Tomasello estimated the RVU of the bursectomy to be 7.05 due to the reduced complexity compared to a lysis and resection of adhesions. Please see the attached letter from Dr. Tomasello. Thus, an RVU of 7.05 gives code 29999 a reimbursement rate of $1,776.18 when multiplied by the same conversion factor. Because the multiple procedure reduction rule applies to CPT code 29999, it is reduced to $888.09" ($95.03 for the PA at 10.7%).

The affidavit continues that *Ms. Acuna states that the bursectomy should be included in code 29826. However, the explanation of code 29826 Ms. Acuna highlights does not describe a bursectomy but "excision of bursal tissue." This differentiates from the procedure performed here, because a debridement/excision of the bursa was not performed, but rather a bursectomy.*

Dr. Tomasello specifically noted that he performed a complete removal of the inflamed bursa. This differentiates from the debridement or excision, which Dr. Tomasello explains is only a partial removal of muscle or cartilage.

In further support, I note the letter from Dr. Tomasello that what was performed herein was a subacromial bursectomy, which is separate and identifiable, involving the examination of the subacromial space, which revealed inflammation of the bursa. There is no specific code for this which is why he utilized CPT Code 29999. Further, in support, he notes the fee schedule for CPT Code 29825 has a relative value unit (RVU) of 8.18 which would allow for $2,060.87. The estimated charge for this unlisted procedure would be slightly lower with an RVU of 7.05 due to the slightly reduced complexity and skill for a bursectomy compared to 29825. Therefore, he came up with a reimbursement of $1,776.18.

Analysis

In the instant matter, I find for the applicant and award $983.12 as the additional amount owed for the bursectomy billed under CPT Code 29999. The additional amount requested for the synovectomy is denied based on the fee schedule.

I accept the analysis by Ms. Acuna; the provider was not entitled to additional reimbursement for the complete synovectomy. Notwithstanding the statements of the surgeon and Ms. Margaryan, I believe the billing for a complete synovectomy, as it pertains to the shoulder, is limited to situations such as rheumatoid arthritis or pigmented villonodular synovitis removal of the entire intraarticular synovium. I do not believe, under these circumstances, the IP's condition warranted the additional charge for this item.

Notwithstanding, I accept the analysis by Ms. Margaryan and the letter from Dr. Tomasello that a complete bursectomy warranted additional payment. Dr. Tomasello performed a subacromial bursectomy, which is separate and identifiable. It involved examining the subacromial space, which revealed inflammation of the bursa. He then removed the inflamed bursa completely. This differentiates from the debridement or excision, which Dr. Tomasello explains is only a partial removal of muscle or cartilage.

Therefore, the surgeon and PA are awarded the additional $888.09 and $95.03 for this procedure.

Accordingly, the applicant is awarded the sum of $983.12.

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**
	Cross Bay Orthopedic Surgery PC	**12/17/22 - 12/17/22**	**$6,449.65**	**$1,887.00**	**Awarded: $888.09**
	Cross Bay Orthopedic Surgery PC	**12/17/22 - 12/17/22**	**$690.10**	**$201.91**	**Awarded: $95.03**
Total			**$7,139.75**		**Awarded: $983.12**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/05/2023 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 two percent per month, simple on a pro rata basis using a thirty day month. With respect to the claim herein, interest will run from May 5, 2023, the date of the filing of this claim, through payment of the claim.

C. Attorney's Fees

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

As this matter was filed **after**February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11

NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with promulgated 11 NYCRR 65-4.6(d).

With respect to this claim, the applicant is entitled to attorney's fees for the medical services provided to the IP for which the applicant is awarded the sum of $983.12.

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, 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.

07/29/2024
(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:
b6deb40bd3733071ced6aba0074d1586

Electronically Signed

Your name: Victor Moritz
Signed on: 07/29/2024