American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Park West Surgical LLC (Applicant)	AAA Case No.	17-24-1340-4410
	Applicant's File No.	3129434
- and -	Insurer's Claim File No.	0549923510003
	NAIC No.	36447
LM Personal Insurance Company (Respondent)		

ARBITRATION AWARD

I, Philip Wolf, 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

1. Hearing(s) held on 09/18/2024
   Declared closed by the arbitrator on 09/18/2024

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

   Lowell Handschu from LM Personal Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$12,614.83**, 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

   Assignor, a 33-year-old female, was involved in a motor vehicle accident on October 4, 2023. As a result of the accident, Assignor sustained an injury to left shoulder. Applicant is seeking reimbursement for a left shoulder arthroscopy performed on January 5, 2024. Respondent asserts a lack of medical necessity defense and fee schedule defense. The issues in dispute are (1) whether Respondent issued a denial based upon a peer review; and (2) whether Respondent has established its fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

Applicant's Prima Facie Case

Assignor was involved in a motor vehicle accident on October 4, 2023. As a result of the accident, Assignor sustained an injury to her left shoulder. On January 5, 2024, Applicant performed a left shoulder arthroscopy. Respondent has acknowledged receipt of Applicant's bill.

After reviewing the evidence submitted by Applicant, I find that Applicant has submitted sufficient credible evidence to establish a prima facie case with respect to the left shoulder arthroscopy performed on January 5, 2024. *See*, Viviane Etienne Med. Care v. Country-Wide Ins. Co., 25 N.Y.3d. 498, 2015 NY Slip Op 04787, (2015).

Respondent's Lack of Medical Necessity Defense

Respondent issued a timely denial allegedly based upon a peer review. However, Respondent has failed to submit a copy of the peer review that is the basis of the denial. Without the peer review, I find that Respondent has failed to establish its lack of medical necessity defense.

Respondent's Fee Schedule Defense

Applicant billed $12,614.83 for the left shoulder arthroscopy which was performed in New Jersey. Respondent asserts that Applicant billed in excess of the applicable fee schedule. Respondent has the burden to come forward with competent evidentiary proof to support its fee schedule defense. *See*, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co.,13 Misc.3d 172, 822 N.Y.S.2d 378, (Civil Ct, Kings Co. 2006). *See, also*, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co., 11 Misc.3d 1065A, 816N.Y.S.2d 700(Civil Ct, Kings Co. 2006).

In support of its fee schedule defense, Respondent has submitted a fee audit and addendum by Melissa Simon, RN, BSN, CPC. Ms. Simon asserts that Applicant is entitled to $2,698.27 pursuant to New Jersey Fee Schedule. MS. Simon states "The amount allowed for professional health services performed outside of New York State for a New York resident shall be the lowest of (1) the amount set forth in the New York fee schedule that has the highest applicable fee; (2) the amount charged by the provider; and (3) the prevailing fee (fee schedule) in the geographic location of the provider."

With respect to CPT code 29805-59, Ms. Simon states "Per General Ground Rule #5 and Surgery Ground Rule #7 of the Fee Schedule for Separate Procedures, certain of the listed procedures are commonly carried out as an integral part of a total service, and as such do no warrant a separate charge. Only if/when a procedure is carried out as a separate entity not immediately related to other services, is the indicated value for the separate procedure applicable. Per the operative record, multiple procedures were performed in addition to: 29823 extensive debridement, 29826 subacromial decompression, 29820 synovectomy, 29825 lysis of adhesions, and code 29806, capsulorrhaphy, all billed at the same operative session. Pursuant to the NYS Fee Schedule, the separate procedure general ground rules #7 and #5 apply to this

service-code 29805, which states that this procedure is commonly carried out as an integral part of a total service and as such does not warrant a separate charge. Therefore, no additional reimbursement can be made." "Of note, provider appended modifier 59 to code 29805. Modifier 59 represents a distinct procedural service. However, per NYS Fee Schedule coding guidelines and AMA CPT coding guidelines, modifier 59 is only used to identify a procedure that is performed in a different session, a different procedure or surgery, a different site or organ system, a separate incision or excision, a separate lesion, or a separate injury (or area of injury in extensive injuries). The submitted operative report does not substantiate the use of modifier 59." Ms. Simon further states "pursuant to NYS Fee schedule, surgery ground rule 5, when multiple procedures unrelated to the major procedure adding significant time or complexity are provided, payment is for the procedure with the highest allowance, in this case code 29823, plus half of the lesser procedures. Codes designated as "add-on" as is 29826 are exempt from this reduction." Ms. Simon concludes that CPT codes 29826, 29823, 29825, 29820, and 29805-59 were not separately reimbursable and Applicant was only entitled to reimbursement for CPT code 29806.

Applicant has submitted a fee schedule affidavit by Thomas Scilaris, M.D., the surgeon who performed the procedure. With respect to CPT code 29805-59 Dr. Scilaris states "the submitted operative report absolutely substantiates the use of modifier 59 as the separate arthroscopy, shoulder, diagnostic with synovial body was not only a separate procedure, but also said distinct surgical procedure required a separate incision and surgical portal." Doctor Scilaris further asserts that Respondent failed to consider Ground Rule 7 which requires a medical determination as to whether procedures are an inherent portion of a procedure."

In her addendum, Ms. Simon states Applicant did not apply modifier 59 to CPT codes 29823, 29820, 29825, and 29826 and "therefore these codes are denied per the New Jersey fee schedule." With respect to CPT code 12001-59, Ms. Simon states "the operative note clearly validates the closure of the portal sites used to access the compartment of the shoulder, in which the provider performed the procedures" and said code is "only used to identify a procedure that is performed in a different session, different procedure or surgery, a different site or organ system, a separate incision or excision, a separate lesion or a separate injury." With respect to 29805-59, Ms. Simon states that Code 29805 "is related to the other shoulder arthroscopy codes and therefore not separately payable per the NYS rule above. Per the New Jersey fee schedule, 29805-59 is denied as modifier 59 is not validated."

After reviewing the evidence, with respect to CPT codes 29826, 29823, 29825, 29820, and 12001-59, I am persuaded by the detailed and thorough analysis of Respondent's certified professional coder, Ms. Simon, as set forth herein. As noted by Ms. Simon, and contrary to Applicant's assertion, Applicant did not apply modifier 59 to CPT codes 29826, 29823, 29825, and 29820, and I agree with her conclusion that said codes were included in CPT code 29806. I also agree with her analysis of CPT code 12001-59 being inclusive as well.

However, with respect to CPT code 29805-59, I find that Dr. Scilaris established that it was a separate and distinct procedure which required a separate incision and

surgical portal. Based upon the foregoing, I find that Applicant is entitled to reimbursement for CPT codes 29806 and 29805-59, for a total of $3,741.30.

DECISION: Based upon the foregoing, Applicant is awarded $3,741.30. This award is in full disposition of all No-Fault benefit claims submitted to this Arbitrator.

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**	**Status**
	Park West Surgical LLC	**01/05/24 - 01/05/24**	**$12,614.83**	**Awarded: $3,741.30**
Total			**$12,614.83**	**Awarded: $3,741.30**

B. The insurer shall also compute and pay the applicant interest set forth below. 03/15/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   Since the claim(s) in question arose from an accident that occurred on or after April 5, 2002, the insurer shall compute and pay the applicant the amount of interest at the rate

of 2% per month, simple, and ending with the date of payment of the award. Respondent timely denied the subject bill and arbitration was not commenced within 30 days after receipt of denial. Accordingly, interest shall begin to accrue as of the date adjudication was commenced by the claimant, i.e., the date the claim was received by the AAA (**03/15/24**). *See*, LMK Psychological Services, P.C. v. State Farm Mut. Auto. Ins. Co., 2009 NY Slip Op 02481 (2009).

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

09/30/2024
(Dated)

Philip Wolf

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:
803c60d85b7aab7ef3393957093ca881

Electronically Signed

Your name: Philip Wolf
Signed on: 09/30/2024