American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

William L. King, M.D. P.C. (Applicant) - and - State Farm Mutual Automobile Insurance Company (Respondent)	AAA Case No. Applicant's File No. Insurer's Claim File No. NAIC No.	17-24-1339-0540 149313 32-57Q0-69J 25178

ARBITRATION AWARD

I, Charles Blattberg, 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: Eligible injured person

1. Hearing(s) held on 09/18/2024
   Declared closed by the arbitrator on 09/23/2024

   Edilaine D'Arce, Esq. from Law Offices of Eitan Dagan participated virtually for the Applicant

   Shaniqua Snell, 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, **$203.52**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant reduced the total amount in dispute to $118.76 pursuant to fee schedule.

   Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

   The claimant was the 59-year-old female restrained front seat passenger of a motor vehicle that was involved in an accident on 10/9/23. Following the accident, the claimant suffered injuries which resulted in the claimant seeking treatment. At issue is

Applicant's physician's assistant's fee associated with a right knee arthroscopy performed on 1/7/24. Respondent raised a fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

Based on a review of the documentary evidence, this claim is decided as follows:

An Applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case for reimbursement.

The claimant was the 59-year-old female restrained front seat passenger of a motor vehicle that was involved in an accident on 10/9/23. The claimant reportedly injured her neck, right shoulder, mid back, low back and right knee. There was no reported loss of consciousness. There were no reported lacerations or fractures. Following the accident the claimant was transported to an unnamed ER where she was evaluated, treated, and released. On 10/10/23 the claimant presented to Mario Leon, P.A. of Atlantic Medical & Diagnostic, PC with complaints of cervical pain rated 8/10 (where 0 is no pain and 10 is the worst pain), right shoulder pain rated 8/10, thoracic pain rated 8/10, lumbar pain rated 8/10 and right knee pain rated 8/10. PA Leon performed ultrasound guided trigger point injections paralumbar muscles 3 sites, ultrasound guided right shoulder intra-articular joint injection and ultrasound guided right suprascapular nerve block. PA Leon prescribed durable medical equipment (DME) consisting of a Therapain Pulsed Laser Therapy unit, Cold Compression unit, Thermosphere, Bed Board, Cervical Collar, Orthopedic Cervical Pillow, Egg Crate Mattress, Orthopedic Lumbar Support, Orthopedic Positioning Seat (driver), Orthopedic Lumbar Cushion (passenger), left shoulder support, left knee support and cold water circulating pump with pad. PA Leon prescribed medications consisting of Cyclobenzaprine, Diclofenac Gel and Lidocaine Ointment. PA Leon ordered MRIs (cervical, right shoulder, thoracic, lumbar and right knee). On 10/12/23 Nick N. Nicoloff, P.A.-C of Home Visits PA, PC prescribed an orthopedic positioning seat, pneumatic compression device and a wearable PEMF device. The claimant was recommended for physical therapy, chiropractic treatment and acupuncture. The 10/17/23 right knee MRI produced an impression of medial meniscus tear, tricompartmental chondromalacia and osteoarthropathy and joint effusion. On 10/25/23 PA Nicoloff ordered VNG testing. On 10/26/23 PA Nicoloff prescribed a shoulder support. On 11/1/23 the claimant presented to William L. King, M.D. of Applicant's office with complaints of right wrist/hand pain rated 3/10, left wrist/hand pain rated 3/10 and right knee pain rated 8/10. Right knee examination revealed no heat, swelling, effusion, erythema, or crepitus appreciated. There was a complaint of tenderness noted on palpation over the joint line. The pain radiated down the leg with a

positive McMurray's test and flexion restricted 115/135. The claimant had complaints of buckling, locking and clicking in the knee. The claimant was recommended for physical therapy. On 11/2/23 PA Nicoloff prescribed a left knee orthosis (rigid). On 11/9/23 PA Nicoloff prescribed a cervical traction unit and a left ankle support. On 11/14/23 PA Leon prescribed DME consisting of EMS unit and belt, massager and infrared heating lamp. On 11/16/23 PA Nicoloff prescribed a Pulsed Electromagnetic Field(PEMF) osteogenesis stimulator and kinesiology tape. During the 12/20/23 follow-up examination conducted by Dr. King right knee examination revealed there was no heat, swelling, effusion, erythema, or crepitus appreciated. There was no complaint of tenderness noted on palpation. The pain was radiating in nature and goes down to leg and up to the thigh. Positive orthopedic tests were Anterior Drawer, Patella grind and McMurray's. Muscles strength was - 4/5 with pain and flexion restricted 125/135. The claimant had complaints of buckling, locking and clicking in the knee. Dr. King determined "based on the severity of the patient's complaints and the nature of the patient's increasing right knee pain, and limitations, the lack of improvement with conservative management, the clinical findings of the patient's right knee, diagnostic (MRI) findings, and orthopedic evaluation, I feel that surgical procedure of the right knee is indicated." On 1/7/24 William King, M.D. (surgeon) and Boris Khaimov, P.A. (surgical assistant) performed right knee arthroscopy consisting of partial medial and lateral meniscectomies, extensive synovectomy, abrasion arthroplasty of patellofemoral compartment, removal of loose bodies and coblation arthroplasty of medial and lateral compartments. On 1/17/24 Dr. King conducted a post surgical follow-up examination noting "Right knee scars are healing and wound portals are clean, dry, and intact. Sutures were removed today. She has moderate tenderness and has a good range of motion. No instability. The patient has mild swelling." Right knee examination revealed there was no heat, effusion, erythema, or crepitus appreciated. There was no complaint of tenderness noted on palpation, but there was swelling noted. Positive orthopedic tests were Patella Grind and McMurray's. Muscle strength was - 4/5 with pain. The claimant had complaints of locking and clicking in the knee. Active range of motion was at 05-125 degrees (0-135 degrees normal). At issue is the 1/7/24 physician's assistant'sfee.

It is respondent's burden to come forward with competent evidentiary proof to support its fee schedule defenses. See *Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co.*, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). See also, *Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co.*, 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. See *Continental Medical PC v. Travelers Indemnity Co.*, 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1 Dep't, per curiam, 2006). A respondent may interpose a defense in a timely denial that the claim exceeds the fees permitted by the Workers' Compensation schedules, but respondent must, at minimum, establish, by evidentiary proof, that the charges exceeded that permitted by law. *Abraham v. Country-Wide Ins. Co.*, 3 Misc.3d 130A, 787 N.Y.S.2d 678, 2004 N.Y. Misc. LEXIS 544 (App. Term, 2d Dept. 2004).

Here, Applicant billed $803.33 and Respondent untimely reimbursed $593.87 with applicable interest. Respondent submitted a Certified Professional Coder (CPC) affidavit from Kristen Savold who indicates that the claim was correctly reimbursed. After the amendment of the amount claimed in dispute is CPT code 29999. Regarding the surgeon's fee for CPT code 29999, Ms. Savold states in pertinent part: "*CPT code 29999 has been reported for Coblation using a radio frequency device. New York Workers' Compensation Fee Schedule Surgery Ground Rule 1B directs: "Payment is for the procedure coded and described, irrespective of the methods or appliances used to perform the procedure. The relative value units are applicable to all physicians who perform the listed services." Therefore, the manner in which the damaged cartilage was removed is not the basis for a code selection, but on the ultimate procedure. CPT Assistant discusses a similar situation: Per CPT Assistant, September 2009 page 11 Surgery: Musculoskeletal System, TOPAZ device (Q&A) Question: What is the appropriate code to report when the TOPAZ device is used to perform a procedure? Answer: The TOPAZ MicroDebrider is a tool which utilizes Coblation® technology to perform a small incision in the fascia and is considered an alternative to the use of standard surgical instruments such as scalpels, low frequency electrocautery, and so forth. This technology enables the microdebridement of soft tissue present within the tendons of the knee, shoulder, elbow, ankle and foot. Because the TOPAZ MicroDebrider is a tool and not a procedure, code selection will depend on the service performed, and the specific anatomy involved, as it can be used on different parts of the body. The appropriate code should be selected based on the definitive procedure being performed as described in the code descriptor Thus, Coblation is debridement which is inclusive to CPT 29880. Therefore, reimbursement is $0.00.*"

Applicant indicates it is entitled to the amended balance of $118.76 in accordance with the New York Workers' Compensation Fee Schedule. Applicant submitted an affidavit by Theresa Carbone, CPC. Ms. Carbone noted that CPT code 29999 is described as "unlisted procedure, arthroscopy", which was billed for, "Coblation Arthroplasty", referring to the language in the operative report. Ms. Carbone further notes: "*Moreover, CPT code 29999 reported to capture a "Coblation Arthroplasty" was denied bundled to CPT code 29880, stating a chondroplasty or debridement of articular cartilage is included in CPT code 29880. However, a chondroplasty was not performed, nor debridement of articular cartilage was mentioned in the Operative Report attached. Please bear in mind, CPT code 29999 does not bundle into any other CPT codes and must be acknowledged By Report as instructed by the New York State Workers Compensation Medical Fee schedule, ground Rule #10. Please make note, the AMA instructs coders to report a CPT code which best describes the procedure performed and not to report a CPT code which merely describes the procedure rendered. Thus, in following the aforementioned guidelines CPT code 29999 was reported to capture a Coblation Arthroplasty because there isn't a CPT code that describes the work performed. A Coblation Arthroplasty would be reported using CPT code 29999 taking into consideration the manner in which the cartilage is treated. CPT code 29877 is debridement performed with a motorized suction cutter. CPT code 29879 is similar, but it uses a pick or drill to create tiny holes in the subchondral bone to promote cartilage regeneration. Coblation is different from these. A wand is inserted into the knee joint,*

and a current is passed within the tip of the wand to create a plasma. This plasma gets very hot and is then used to melt the cartilage, but without tissue damage. CPT code 29999 "coblation arthroplasty" has a total allowance of $1,957.57 based on the geographic location of the services rendered. Reimbursement is calculated using the following formula: surgical conversion fact 251.95 X relative value unit (RVU) 7.77= 1,957.57@ 50% (for multiple procedure reduction) = $978.79." As to the physician's assistant fee at issue here Ms. Carbone notes that "*for the applicable physician assistant's fees to be paid at 10/7% of the surgeon's fee as per NYS Workers' Compensation Medical Fee Schedule Guidelines*."

"An insurer who raises this defense will prevail if it demonstrates that it was correct in its reading of the fee schedules unless the plaintiff shows that "an unusual procedure or unique circumstance justifies the necessity" for a charge above the schedules fee. 11 NYCRR 68.4." *Jesa Medical Supply, Ind. V. Geico Ins. Co.*, 2009 NY Slip Op. 29386, 25 Misc. 3d 1098, (Civ. Ct. Kings Co. 2009). After a thorough review of both parties' submissions, I am more persuaded by Respondent's position. I agree with Respondent's detailed analysis and find that CPT code 29999 billed by the physician's assistant was properly denied. Therefore, 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 Nassau

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

10/18/2024
(Dated)

Charles Blattberg

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:
664b4193190e40c855c0fdafe8059653

Electronically Signed

Your name: Charles Blattberg
Signed on: 10/18/2024