American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Tri-Borough NY Medical Practice PC (Applicant)	AAA Case No.	17-24-1347-0775
	Applicant's File No.	N/A
- and -	Insurer's Claim File No.	03275935-2023
	NAIC No.	Self-Insured
Repwest Insurance Company (Respondent)		

ARBITRATION AWARD

I, Mary Anne Theiss, 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 12/30/2024
   Declared closed by the arbitrator on 12/30/2024

   Rajesh Barua, Esq. from Law Offices of Hillary Blumenthal LLC (Hoboken) participated virtually for the Applicant

   Matthew Grumet, Esq. from Husch Blackwell LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$469.72**, 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
   The male Claimant with a date of birth of November 2, 1997, was involved in an automobile accident on October 1, 2023.

   The Applicant Tri-Borough NY Medical Practice PC is seeking $469.72 for the date of service January 5, 2024.

   The issue is the fee schedule.

4. Findings, Conclusions, and Basis Therefor

The male Claimant with a date of birth of November 2, 1997, was involved in an automobile accident on October 1, 2023.

The Applicant Tri-Borough NY Medical Practice PC is seeking $469.72 for the date of service January 5, 2024.

The issue is the fee schedule.

Under New York State No-Fault Law an Applicant can make a prima facie showing of medical necessity by submitting "…a properly completed claim form, which suffices on its face to establish the "particulars of the nature and extent of the injuries and [health benefits] received and contemplated" (11 NYCRR 65-1.1), and the "proof of the fact and the amount of loss sustained." (Insurance Law section 5102 [a]) See Amaze Medical Supply Inc. a/a/o Johnny Bermudez v. Eagle Insurance Company 784 N.Y.S.2d 918 and Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004).

The bills in question are for the physician assistant. AAA Case No. 17-24-1347-0776, the services for the physician are $4,985.89. The physician services were billed at $8,830.50, $3,844.61 was paid leaving a balance of $4,985.89. For the physician assistant portion of the bill $881.09 was billed, $411.37 was paid leaving a balance of $469.72.

The Carrier produced an affidavit from Jennnifer Takac, CPC, CPMA. (DATED?) Ms. Takac based her audit and payment suggestion on the New York State Fee Schedule. The New Jersey Fee Schedule would have been less expensive. The Carrier's position is that they overpaid.

Ms. Takac noted that physician assistants and nurse practitioners assisting during surgical procedures are paid two-thirds of the surgical assistant percentage (16.0%). Physician assistants receive 10.7% of the total allowance for the surgical procedure. She noted that code 99213 for date of service November 8, 2022, pursuant to Ground Rule #2 peri-operative visits are included in the limited value of the surgical procedure, i.e. immediate pre-op visits and other services were included in the value of the surgical procedure, therefore there was no reimbursement for code 99213.

For code 0232T, this is a platelet-rich plasma (PRP) inter-operative injection in the right knee. This is substantiated in the operative report and is recommended at 50% per Ground Rule #5 of the Multiple Procedure Rule in which payment is for the procedure with the highest allowance plus half of the lesser procedure.

For code 20610, payment was not recommended as procedures include surgery and local infiltration, digital original blocks.

Code 29884 was not recommended for reimbursement. This is a separate procedure code and is not reimbursed when the procedure is on ipsilateral knee in the same operative procedure. Code 29884 was reported with modifier 59, Ms. Takac says that that was inaccurate. The procedure was performed on the right knee in the same operative session and using modifier 59 does not meet the criteria of a different site or organ system, separate incision/excision, separate lesion, or separate injury.

Code 29876 was substantiated. It was a synovectomy performed on three compartments of the knee. The recommendation was 50% of the allowance. Ms. Takac recommended that code 2999 be changed to the correct code for the procedure which is 29877. Code

29877 is inclusive in the primary procedure and is not recommended for reimbursement. She noted that the procedure performed was a chondroplasty which is code 29877. She noted that coblation is not a procedure, it is a technique using RF wand to excise the chondroplasty procedure. She noted that code 29880 is substantiated by the operative report and reimbursed at 100%.

I agree with Ms. Takac's analysis and the claim is denied.

I want to thank the parties for taking the time to prepare their cases and participate in the arbitration process.

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 NY

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

12/30/2024
(Dated)

Mary Anne Theiss

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:
96cefdf074a32e07fa994b4b6195f11d

Electronically Signed

Your name: Mary Anne Theiss
Signed on: 12/30/2024