

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Interventional Spine Medicine Treatment  
PLLC  
(Applicant)

- and -

Allstate Fire & Casualty Insurance Company  
(Respondent)

AAA Case No.	17-24-1360-1126
Applicant's File No.	N/A
Insurer's Claim File No.	0747540409 JSY
NAIC No.	29688

**ARBITRATION AWARD**

I, Rebecca Novak, 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 ["LA"]

1. Hearing(s) held on 02/25/2025  
Declared closed by the arbitrator on 02/25/2025

Usman Nawaz, Esq. from Law Offices of Hillary Blumenthal LLC (Union City)  
participated virtually for the Applicant

Marilyn Oppedisano, Esq. from Law Offices of John Trop participated virtually for the  
Respondent

2. The amount claimed in the Arbitration Request, **\$1,952.42**, was NOT AMENDED at the oral hearing.  
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bills and to the timeliness of Respondent's denials.

3. Summary of Issues in Dispute

Whether Applicant established entitlement to additional No-Fault insurance compensation for the surgeon's fees for left shoulder arthroscopy and a follow-up office visit, performed on May 21, 2024 and June 18, 2024, respectively, to treat Assignor, a

44-year-old female, subsequent to being injured in a motor vehicle accident on March 5, 2024.

Whether fees were not in accordance with fee schedule.

#### 4. Findings, Conclusions, and Basis Therefor

In this No-Fault insurance arbitration, Applicant is seeking as additional compensation \$1,952.42 for the surgeon's fees for left shoulder arthroscopy and a follow-up office visit performed on May 21, 2024 and June 18, 2024, respectively, to treat Assignor, a 44-year-old female, who was injured in a motor vehicle accident on March 5, 2024. Respondent made partial payment and denied the balance of the claim based on fee defenses.

Both parties appeared at the hearing via Zoom by counsel, who presented oral argument and relied upon documentary submissions. I have reviewed the submissions' documents contained in the American Arbitration Association's ADR Center as of the date of the hearing, said submissions constituting the record in this case.

Stipulations were entered into at the hearing, amongst which were that Applicant established a prima facie case of entitlement to No-Fault compensation for the amount it sought and that Applicant's bills were timely denied by Respondent.

Applicant utilized CPT Codes 29823, 29825, 29821, and 29999-59 to represent services by the surgeon. Applicant also billed \$50.26 for a follow-up office visit under Code 99212. With regard to CPT Codes 29823, 29825, and 29821, both Applicant and Respondent were in agreement as to how much should have been billed. Remaining in dispute is how much should have been billed for CPT Code 29999-59 (billed at \$1,902.15) and for the office visit.

Applicant is seeking what remains unpaid from the surgeon's fees after making its own adjustment pursuant to the multiple procedure rule and its interpretation of the fee schedule with regard to the bill utilizing BR code 29999, as well as for the follow-up office visit.

Defendant has the burden to come forward with competent evidentiary proof to support its fee schedule defenses. Robert Physical Therapy PC v. State Farm Mutual Auto Ins.Co., 2006 NY Slip Op. 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). If an insurer presents sufficient evidence to substantiate its fee schedule calculation, the burden shifts to the medical provider to raise a triable issue of fact regarding the insurer's fee schedule interpretation. Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A) (App Term 1st Dept. 2011).

Pursuant to 11 NYCRR 65-4.5(o)(1), the arbitrator shall be the judge of the relevance and materiality of the evidence offered and strict conformity to legal rules of evidence

shall not be necessary. Furthermore, the Workers' Compensation fee schedule, which is required by law and incorporated by reference into the Insurance Department Regulations, is of such sufficient authenticity and reliability that it may be given judicial notice, and it need not be submitted to the court. Z.A. Acupuncture, P.C. v. Geico Ins. Co., 33 Misc.3d 127(A), 939 N.Y.S.2d 745 (Table), 2011 N.Y. Slip Op. 51842(U), 2011 WL 4949646 (App. Term 2d, 11th & 13th Dists. Oct. 11, 2011); Lvov Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), 939 N.Y.S.2d 741 (Table), 2011 N.Y. Slip Op. 51721(U), 2011 WL 4424472 (App. Term 2d, 11th & 13th Dists. Sept. 16, 2011). As a court may take judicial notice of the fee schedule, so too may I, as an arbitrator.

Respondent submitted a fee coder affidavit from Carolyn Mallory, CPC, in support of its position concerning the fees for the surgeon's bill. As noted above, remaining in dispute is how much should have been billed for CPT Code 29999-59 (billed at \$1,902.15).

In her analysis, Ms. Mallory relied on the New York Workers' Compensation Medical Fee Schedule, its General Guidelines, the CPT Assistant published by the AMA, as well as the Introduction section of the CPT book. She first explained how she utilized General Ground Rule #5 (for multiple or bilateral procedures). With regard to Code 29999-59, a By Report code, she stated that Ground Rule #3 in the Introduction and General Guideline section of the Medical Fee Schedule would apply, which requires that for procedures without Specified Unit Values, for any procedure where the unit value is listed in the schedule as "BR", the physician shall establish a unit value consistent in relativity with other unit values shown in the schedule. She explains in detail that the operative note indicates that Code 29999 was used for bursectomy but based on the CPT Assistant, the procedure described should be reported with Code 29822 or 29823, depending on the extent of debridement of the whole shoulder. In this case, Ms. Mallory explained that the procedure performed was in fact an included component of Code 29823, and thus should get a reimbursement of \$0.

Based on her calculations and explanations, Ms. Mallory concluded that Applicant should be reimbursed \$4,075.13 for the surgeon's fee. That is what Respondent paid and thus nothing further is owed according to Respondent's fee coder.

Respondent's fee affidavit did not address the follow-up office visit, but in its denial, Respondent stated: "This procedure/service is considered to be part of the global surgical package which includes all normal follow-up care for the period indicated in the New York Workers' Compensation Medical Fee Schedule (Surgical Ground Rule 1)."

Applicant did not submit its own fee coder affidavit, but relied upon a "Comparison Letter." This letter is submitted by Applicant's Medical Billing Department. In that letter, the author asserted that Code 29999 was billed because "there is no other code which best describes the work performed." It was explained that Code 29822 was used as the "comparison code for the extensive Bursectomy performed within the Subacromial Bursal Space, which was documented on page 2 of the report, to reflect the same RVU, hence billing the amount of \$1,902.15."

I have reviewed Respondent's fee coder affidavit and determine that it is credible and more persuasive than the "comparison letter" submitted by Applicant. Ms. Mallory's

affidavit is detailed and comprehensive, with supporting documentation. In contrast, Applicant's comparison letter is not signed and it is not clear who actually wrote it. I find an opinion on fees which is not signed by an expert or at the very least by a doctor, to carry less weight.

Based on the evidence presented in this case, I sustain Respondent's fee defense with regard to the surgeon's bill. Thus Respondent's fee defense overcomes Applicant's prima facie case of entitlement to No-Fault compensation with regard to the surgeon's bill.

As to the office visit billed under CPT Code 99212 in the amount of \$50.26, I find that neither at the hearing nor in its submission did Respondent have an explanation supporting the denial. The defense of fees not being in accordance with fee schedule must be rejected where the insurer fails to address how the amount charged by the provider was in excess of the fee schedule. E.g., Jesa Medical Supply, Inc. v. GEICO Ins. Co., 25 Misc.3d 1098, 887 N.Y.S.2d 482 (Civ. Ct. Kings Co. 2009).

I therefore reject Respondent's defense for date of service June 18, 2024 and find that Applicant's prima facie case to entitlement for No-Fault compensation stands. I award Applicant \$50.26 for the office visit performed.

Accordingly, the within arbitration is granted to the extent of \$50.26.

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
	<b>Interventional Spine Medicine Treatment PLLC</b>	<b>05/21/24 - 05/21/24</b>	<b>\$1,902.16</b>	<b>Denied</b>
	<b>Interventional Spine Medicine Treatment PLLC</b>	<b>06/18/24 - 06/18/24</b>	<b>\$50.26</b>	<b>Awarded: \$50.26</b>
<b>Total</b>			<b>\$1,952.42</b>	<b>Awarded: \$50.26</b>

- B. The insurer shall also compute and pay the applicant interest set forth below. 08/08/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The date set forth above is the date when the American Arbitration Association received the arbitration request.

Applicant did not commence arbitration within 30 days after receipt of the denial(s). Therefore, the interest accrual date shall be the said date the American Arbitration Association received the arbitration request. The end date for the period of interest shall be the date of payment of the claim. Interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. See 11 NYCRR 65-3.9, 65-4.5(s)(3).

C. Attorney's Fees

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

Applicant is entitled to an attorney's fee pursuant to Insurance Law §5106(a). After calculating the sum total of the first-party (No-Fault) benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, subject to the following limitations: In the event the above filing date was prior to Feb. 4, 2015, the attorney's fee is subject to a minimum of \$60.00 and a maximum of \$850.00, per 11 NYCRR 65-4.6(e). In the event the above filing date was on or after Feb. 4, 2015, the attorney's fee is subject to a maximum of \$1,360.00, per 11 NYCRR 65-4.6(d). In the event the above filing date was on or after Feb. 4, 2015 and first-party (No-Fault) benefits are awarded to more than one Applicant herein, the

attorney's fee shall be calculated separately for each Applicant, each Applicant's attorney fee being subject to the \$1,360.00 maximum.

- 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 Nassau

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

02/26/2025

(Dated)

Rebecca Novak

### **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:**  
7f8bd786361afd1b90bc69596dc5c428

### Electronically Signed

Your name: Rebecca Novak  
Signed on: 02/26/2025