

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Paramount Medical Services PC
(Applicant)

- and -

State Farm Mutual Automobile Insurance
Company
(Respondent)

AAA Case No. 17-18-1085-6857

Applicant's File No. RFA18-207047

Insurer's Claim File No. 32-1320-2C0

NAIC No. 25178

ARBITRATION AWARD

I, Michael B. Parson, 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: DH

1. Hearing(s) held on 06/07/2019
Declared closed by the arbitrator on 06/07/2019

Helen Feingersh, Esq. from Russell Friedman & Associates LLP participated in person for the Applicant

John Rossillo, Esq. from Rossillo & Licata LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,942.41**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated to the timely service of all bills and denials, to Applicant's *prima facie* showing of entitlement to reimbursement and that any interest due shall run from the date the AR1 was emailed to, or if mailed, received by the American Arbitration Association.

3. Summary of Issues in Dispute

The sole issue to be determined is whether Applicant's billing was in accordance with the applicable provisions of the New York Workers' Compensation Medical Fee Schedule.

4. Findings, Conclusions, and Basis Therefor

DH, a female who was then 52 years old, was involved in an automobile accident on 4/13/17 while driving. She sustained various injuries and was administered a platelet rich plasma injection by the Applicant on 10/30/17. Reimbursement for the injection was partially denied on fee schedule grounds.

Applicant reported an office visit that was reimbursed and not in issue here and the injection under CPT code 0232T in the sum of \$2,306.50. Respondent reimbursed \$364.17, citing the fee schedule and leaving \$1,942.33 in dispute, Applicant's AR1 being \$.08 in error. In support of its defense, Respondent submitted the affidavit of Matthew D. Kenyon, CPC, CPMA. Applicant has submitted no evidence regarding its billing.

The code reported by the Applicant is a By Report (BR) code. The ground rules, in identical language in each place the issue is addressed, read as follows:

Procedures Listed without Specified Relative Value Units:

By Report (BR) items: "BR" in the relative value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records; hence the importance of documentation. The original official record, such as operative report and hospital chart, will be given far greater weight than supplementary reports formulated and submitted at later dates. For any procedure where the unit value is listed in the schedule as "BR", the physician shall establish a relative value unit consistent in relativity with other relative value units shown in the schedule. The insurer shall review all submitted "BR" unit values to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items. [emphasis added]

The Ground Rule provides an initial affirmative duty that rests with the provider. In this case, applicant did not provide any of the support, documentation or other information necessary to substantiate applicant's choice of charges for its "BR" injection. Applicant's

treatment notes do not provide the information required by the fee schedule to substantiate Applicant's charges. In addition, applicant has not established a "relative value unit consistent in relativity with other relative value units shown in the schedule." Applicant has done nothing to support its billing choice.

This raises the question as to which party bears the *prima facie* burden of establishing the correct reimbursement and whether Respondent had to justify its unilateral action with an affidavit or by virtue of first seeking further verification from the Applicant relative to the BR code billed. I find that it did. The affirmative duty to justify the BR billing is on the Applicant upon presentment of its bill. A provider bears the burden of coming forward with a basis for its determination of the "prevailing fee" when the applicable regulations make that the benchmark for permissible charges. I make clear that this does not create an additional burden on a provider in the context of litigation. *Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co.*, 25 N.Y.3d 498, 501, 14 N.Y.S.3d 283, 286 (2015) reiterates the long standing limited *prima facie* burden of a provider in arbitration or in court. However, a carrier may seek additional verification (see, *Bronx Acupuncture Therapy, P.C. v. Hereford Ins. Co.*, 54 Misc.3d 135[A], 2017 NY Slip Op 50101[U], [App Term 2d, 2d, 11th, and 13th Dists. [2017] and *Gaba Med. P.C. v. Progressive Specialty Ins. Co.*, 36 Misc. 3d 139 [A], 2012 NY Slip Op 51448[U], [App Term, 2d Dept, 2d, 11th & 13th Jud Dists [2012]) or choose to down grade the bill if it provides a basis for how it does so. In the context of litigation, once the insurer meets its burden of establishing its defense, it is incumbent on the Applicant to then prove its justification. That is, once an insurer makes a *prima facie* showing that the amounts charged by a provider were in excess of the fee schedule, the burden shifts to the provider to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. *Cornell Medical, P.C. v. Mercury Casualty Co.*, 24 Misc.3d 58, 884 N.Y.S.2d 558 (App. Term 2d, 11th & 13th Dists. 2009).

Here, Respondent had the right to review applicant's "BR" charges for consistency. Respondent reviewed the charges and reimbursed based on that review. For litigation purposes, it sought a review by Mr. Kenyon who found the reimbursement to be more than the Applicant was entitled to receive. He wrote, in pertinent part:

Based on the documentation for date of service 10/30/2017 the provider has performed a Platelet Rich Plasma injection to the Left Shoulder.

The correct CPT code to be reported based on the documentation is CPT code 0232T (Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed).

CPT Assistant May 2012 page 11

Coding Brief: Bone Marrow Aspiration/Injection of Platelet/Stem Cells (0232T)

Category III code 0232T, Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when

performed, was implemented effective July 1, 2010. Since implementation of code 0232T we have received questions related to the use of code 0232T when platelet rich stem cells are derived by bone marrow aspiration as opposed to venous blood collection.

Example: What code(s) should be reported for the purpose of deriving and injecting platelet rich stem cells from bone marrow aspirate for a patient with a diagnosis of nonunion of tibia fracture? Using a core needle and trocar, bone marrow aspiration into a 60-cc syringe was performed. Via a separate trocar insertion site, 35 cc of bloody aspirate was obtained, and the aspirate was prepared to obtain the platelet rich cells (ie, hematopoietic stem cells and mesenchymal stem cells). Next, the plate and screws were removed from the tibia. The platelet stem cells were then injected through a small stab incision into the tibial nonunion site.

In this example, CPT Category III code 0232T should be reported for the injection into the operative site of the platelet rich plasma containing the stem cells. The harvest of bone marrow and bloody aspirate from the right iliac crest into a 60-cc syringe is considered inherent in code 0232T. Code 0232T is reported in addition to the definitive tibial fracture nonunion repair code (27724). Since CPT coding guidelines may, however, differ from third-party payer guidelines, eligibility for payment, as well as coverage policy, is determined by each individual insurer or third-party payer. For reimbursement or third-party payer policy issues, please contact your local third-party payer.

Category III code 0232T involves collection of the specimen (either by venous blood collection or bone marrow aspiration), which is then spun down and the platelet rich plasma that is collected is injected into the operative site. Code 0232T also includes any imaging guidance used for harvesting and the preparation for injection. Therefore, it is not appropriate to report code 86999, Unlisted transfusion medicine procedure, for obtaining and centrifuging the blood drawn or to report code 86985, Splitting of blood or blood products, each unit, to describe the derivation of the platelets. In addition, none of the codes specific to aspiration or harvesting of bone marrow (eg, 38220, 38230, etc.) would be appropriate to report when the procedure is being performed to obtain platelet rich plasma.

CPT code 0232T has "BR" as a relative value unit (RVU). Per the NY Workers Compensation Medical Fee Schedule, Ground

Rules #'s 2 and 3 "When an unlisted service or procedure is provided, the procedure should be identified and the value

substantiated by report (see rule 3 below). For any procedure where the relative value unit (RVU) is listed as BR, the physician

shall establish a relative value unit consistent in relativity with other relative value units shown in the schedule".

CPT codes 20610 (Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance) and 38220 (Diagnostic bone marrow; aspiration(s)) have been used for RVU purposes as they are both consistent in relativity to the services provided.

Formula: $20610 \text{ RVUs} = 25 + 38220 \text{ RVUs} @ .59 = .84 \text{ RVUs}$

CPT code 0232T according to the Official New York Workers' Compensation Medical Fee Schedule, Surgical Fee Schedule has a total allowable of \$192.39 based on the geographic location of the services rendered. Reimbursement was calculated by the following formula: surgical conversion factor 229.04 X relative value unit .84 = 192.39

I find Mr. Kenyon's analysis to be credible, well reasoned and accurate based on the sources he both cited and submitted. As such, I find that the Respondent overpaid Applicant.

Accordingly, 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 New York
SS :
County of Suffolk

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

06/09/2019
(Dated)

Michael B. Parson

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:
9279fd881e7e590f3f18a65ad39deac5

Electronically Signed

Your name: Michael B. Parson
Signed on: 06/09/2019