

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Tim Canty M.D. PLLC
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No. 17-20-1187-4450
Applicant's File No. WashingtonV3
Insurer's Claim File No. 0503262120101011
NAIC No.

ARBITRATION AWARD

I, Pamela Hirschhorn, 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: Injured Person

1. Hearing(s) held on 10/15/2021
Declared closed by the arbitrator on 10/15/2021

James Errera, Esq. from Dash Law Firm, P.C. participated for the Applicant

Daniel Lissauer, Esq. from Geico Insurance Company participated for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 13,570.67**, was AMENDED and permitted by the arbitrator at the oral hearing.

\$3,179.64.

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

3. Summary of Issues in Dispute

The injured person was a 62-year-old male driver of a motor vehicle involved in the subject accident of February 12, 2019. The claim for services performed June 12, 2020 through June 23, 2020, was timely denied based upon the IME report of Gary Florio, M.D., referencing an IME performed on August 19, 2019. Respondent also submitted a fee audit in

support of its fee schedule defense. The issues to be decided are whether respondent established prima facie that the services rendered subsequent to the IME were not medically necessary and that the services were not billed in accordance with fee schedule.

4. Findings, Conclusions, and Basis Therefor

The injured person was a 62-year-old male driver of a motor vehicle involved in the subject motor vehicle accident of February 12, 2019. The claim for services performed June 12, 2020, through June 23, 2020, was timely denied based upon the IME report of Gary Florio, M.D., referencing an IME performed on August 19, 2019. At the time of hearing, applicant's counsel amended the amount in dispute to \$3,179.64.

The IME report reflects that the injured person had continuing complaints of pain to the neck, lower back, right knee, left shoulder and left hip. There were deficits in ranges of motion of the thoracic spine and lumbar spine. There was tenderness upon palpation of the cervical spine. There was decreased range of motion in the left hip. Deep tendon reflexes were 1+ bilaterally. The IME doctor concluded that the injured person's condition had resolved, and that continued treatment was not medically necessary. Since there were continuing complaints and positive findings at IME, this arbitrator finds that the IME failed to establish prima facie that the injured person's condition had resolved, and that continued treatment was not medically necessary. Moreover, an examination report from the treating doctor, Dr. Ali Malik, D.O., referencing an examination performed on July 8, 2019, reflects that the injured person had continuing complaints and findings.

Thus, this arbitrator finds that the injured person's condition had not resolved as of the date of the IME performed and continued treatment was medically necessary.

Respondent also asserted that the services were billed in excess of fee schedule and submitted the fee audit of Carolyn Mallory, CPC, in support of its fee schedule defense.

Regarding bill #1, Ms. Mallory noted the following:

Applicant billed Code 87635 - $RVU = 51.33 \times 1.19 = \61.08

Applicant billed Code 99213 - $RVU = 5.83 \times 10.99 = \64.07

Regarding bill #2, Ms. Mallory noted that Code 99213 - 25 \$0.00. Pursuant to Ground Rule #2 in Surgery Section of the fee schedule: Immediate preoperative visits and other services by a surgeon. Under most circumstances, including ordinary referrals the immediate preoperative visit in the hospital or elsewhere necessary to examine the patient, complete the hospital records and initiate the treatment program is included in the listed value for the surgical procedure. See, CPT Assistant dated March 2012 / Volume 22 Issue 3 regarding evaluation & management service the same date as a scheduled procedure. Ms. Mallory noted that Code 20999 is not the correct CPT code for PRP injections into a joint and found that the appropriate code is 0232T - RVU = BR (By Report) Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed. Ms. Mallory noted that CPT code 0232T has "BR" (by report) under the RVU (relative value unit) column. Ground Rule #3 on page 13 in the Introduction and General Guideline section of the Medical fee Schedule and Ground Rule #10 in the Surgery section of the fee schedule would apply. Per New York Workers' Compensation fee schedule General Rule #3 titled "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. The ground rules also state that the insurer shall review all submitted "BR" unit values to ensure that the relativity consistency is maintained. The amount allowed is based on documented time, skill, and equipment. Ms. Mallory noted that the physician injects platelet rich plasma (PRP) into a targeted site. Harvesting and preparation may also be performed using a variety of techniques. In one, venous blood is drawn from the region of the arm in front of the elbow (antecubital vein) using a butterfly needle. The blood is placed into an appropriate container, centrifuged, and separated into platelet poor plasma (PPP), RBC, and PRP. The PPP is extracted and discarded and the PRP is withdrawn for use. The injection site is marked in order to localize the PRP injection; image guidance may be used. Under sterile conditions, the physician injects the PRP directly into the target area, sometimes using lidocaine or Marcaine. If administered to a joint space, calcium chloride and thrombin may also be added in order to provide a gel matrix for the PRP to adhere to. She noted that PRP has many indications, including wound care for the treatment of

diabetic and venous stasis ulcers, chronic nonhealing tendon injuries, plantar fasciitis, and augmentation and fusion of bone. She noted that studies suggest that PRP can aid in wound and soft tissue healing and can affect narcotic requirements, bone production (osteogenesis), postoperative blood loss, and inflammation. Based on the CPT description, Ms. Malloy applied the relative value of 1.59, and attached definitions of CPT codes 36511, 36512, 36513 and 36514. In following ground rule #3, she stated that the relative value of 1.59 was used for isolating the platelets and $1.59 \times 229.04 = \$364.17$. For aspiration of bone marrow, Ms. Mallory used the RVU (relative value unit) of CPT code 38220 - Bone Marrow; aspiration only or $.59 \times 229.04 = \$135.13$, then reduced by 50% per ground rule #5 = \$67.66. Thus, Ms. Mallory found that the total allowed for Codes 20999/0232T = \$431.83. She noted that Code 20611 - is a By Report with no relative value. She noted that Ground Rule #3 on page 13 in the Introduction and General Guideline section of the Medical fee Schedule and Ground Rule #10 in the Surgery section of the fee schedule would apply. Per New York Workers' Compensation fee schedule General Rule #3 titled "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 noted that the ground rules also state that the insurer shall review all submitted "BR" unit values to ensure that the relativity consistency is maintained. The amount allowed is based on documented time, skill, and equipment. Ms. Mallory found that CPT code 20611 includes the injection and the ultrasound. Ms. Mallory used the relative value of CPT 20610 and 76492 in order to determine the reimbursement for CPT 20611. Code 20610 - RVU = $.25 \times 229.04 \times .25 = \57.26 , then reduced by 50% per ground rule #5 = \$28.63 (Injecting the platelets back into the site.) Code 76942 - RVU = $4.97 \times 52.90 \times 4.97 = \262.91 .

$\$28.62 + \$262.91 = \$291.54$ (The physician only billed \$126.26 so Ms. Mallory found that it only reimburses to the billed amount) 99070 - \$300.00. Ms. Mallory noted that per Ground Rule #16 Materials Supplied by the Physician--Payment shall not exceed the invoice cost of the item, applicable taxes and shipping and handling costs. The manufacturer's invoice indicated \$300.00 per kit.

Ms. Mallory noted that pursuant to Ground Rule #5 - Multiple or Bilateral Procedures, when multiple procedures, unrelated to the major procedure and adding significant time or complexity are provided at the same

operative session, payment is for the procedure with the highest allowance plus half of the lesser procedures. Ms. Malloy concluded that the New York Fee Schedule amount for bill #1 is \$951.08, and the New York Fee Schedule amount for bill #2 is \$858.09.

Applicant submitted a fee audit by Eddie Hearn, CPC. Mr. Hearn noted that the provider submitted a bill for \$137.80 for DOS 6/12/2020 which included an office visit and Covid-19 probe. Mr. Hearn stated that he is in agreement with respondent's fee coder that the total amount that is reimbursable is \$125.15 [\$64.07 (99213) + \$61.08 (87635)]. As for the left hip PRP injection performed on June 16, 2020, Geico submitted a report from a fee coder advocating that the proper amount is \$825.93. Mr. Hearn disagreed with respondent's fee coder's calculation. He noted that on the date at issue, the provider performed and billed for an office visit under code 99213, an injection under code 27096, autologous tissue transplantation (PRP injection) under code 20999 and supplies under code 99070. With regard to the office visit, (CPT code 99213), Mr. Hearn found that the proper reimbursement should be \$64.07 (10.99 CF x 5.83 RVU). He noted that the injured person appeared for a follow up office visit on 6/16/2020, and his hips, right knee, cervical and lumbar back were fully examined and the PRP injection was given as a result of that examination, not previously scheduled. Mr. Hearn stated that reimbursement for the visit should be allowed in the amount of \$54.07. With regard to the lidocaine injection, (CPT code 27096), Mr. Hearn was in agreement with Geico's fee coder that this code should be reimbursed at \$119.10 (229.04 CF x 1.04 RVU x 50%) as this was a secondary procedure in addition to the PRP and subject to a 50% reduction pursuant to Surgery Ground Rule #5. Thus, Mr. Hearn found that \$119.10 remains outstanding.

Mr. Hearn noted that the procedure billed pursuant to CPT 20999, is called platelet rich plasma injections (PRP injection). With CPT 20999 having an RV rate listed as being a by report code, the Surgery Ground Rules 10(d) directs the use of the RV units billed to be consistent in relativity with other relative value units shown in the schedule. Mr. Hearn stated that a review of the procedure note indicated that the platelet rich plasma injection involved the extraction of blood, depletion of plasma to obtain a concentration of platelet rich plasma, and an injection of the platelet rich plasma under ultrasonic guidance. Thus, Mr. Hearn found that the following CPT codes involve procedures similar to each step involved in the platelet rich plasma injection:

§ CPT 50390 - Aspiration and/or injection of renal cyst or pelvis by needle

§ CPT 36513 - Therapeutic apheresis for platelets

§ CPT 27093 - Injection for hip arthrography

§ CPT 76942 - Ultrasonic guidance for needle placement

Therefore, Mr. Hearn found that the reasonable RV unit would be the sum of the RV units of these procedures and that the multiple reduction rule is not applicable in this case since these separate codes are being used to arrive at an appropriate reimbursement rate for a by-report code. Based on Mr. Hearn's analysis, the total proper reimbursement amount for CPT 20999 is as follows: for CPT 50390, the proper reimbursable amount is \$300.04 (229.04 CF x

1.31 RV). For CPT 36513, the proper reimbursable amount is \$364.17 (229.04 CF x

1.59 RV). For CPT 27093, the proper reimbursable amount is \$135.13 (\$229.04 x

.59) For CPT 76942, the proper reimbursable amount is \$262.91 (52.90 CF x

4.97 RV). Thus, Mr. Hearn found that \$1,062.25 remains outstanding for the PRP hip injection.

As for the invoice, Mr. Hearn noted that CPT 99070, entitles direct reimbursement at the invoice price for items that are not part of a customary surgical package. Under General Ground Rule 4 and Surgery Ground Rule 16 CPT 99070 is for "supplies and materials provided by the physician" with reimbursement limited to invoice cost, taxes and shipping and handling. As PRP supplies kits provided are not part of a customary surgical package, Mr. Hearn stated that they are reimbursed at the amounts shown on the invoice, in this case \$300.00, which is in accordance with respondent's fee coder's audit.

With regard to the right knee PRP injection performed on June 23, 2020, Mr. Hearn stated that the office visit, billed pursuant to CPT code 99213, should be reimbursed in the amount of \$64.07 (10.99 CF x 5.83 RVU). Mr. Hearn noted that the injured person appeared for a follow up office visit on 6/23/2020, and his hips, right knee, cervical and lumbar back were fully examined and the PRP injection was given as a result of that examination, not previously scheduled. Mr. Hearn stated that reimbursement for the visit should be allowed in the amount of \$64.07. As for the lidocaine injection, (CPT code 26011), Mr. Hearn was in agreement with Geico's coder that this code as a by report code should be reimbursed as comparable code 26010 and 76942 for guidance. The amount of \$126.26 [(229.04 CF x .25 RVU) + (52.90 CF x 4.97 RVU) x 50%] as this was a secondary procedure in addition to the PRP and subject to a 50% reduction pursuant to Surgery Ground Rule #5. Thus, Mr. Hearn found that \$126.26, remains outstanding. With regard to CPT code 20999, Mr. Hearn stated that this represents the autologous platelet rich plasma (PRP) tissue transplantation. As this code has an RV listed as being 'by report', Surgery Ground Rule 10(d) directs that the RV units billed to be consistent in relativity with other relative value units shown in the schedule. Mr. Hearn stated that Ms. Mallory correctly noted that a PRP injection would fall under the description of code 0232T however such code is designated by the AMA as a 'Category III' and is not adopted for inclusion in the Workers' Compensation Fee Schedule. Additionally, this code does not have an assigned value and is likewise listed as 'by report'. Therefore, Mr. Hearn stated that regardless of whether the procedure was billed under code 20999 or 0232T the proper reimbursement would be determined by the same comparative analysis. He stated that a review of the procedure note indicated that the platelet rich plasma injection involved the extraction and collection of blood by needle, depletion of blood to obtain a concentration of platelet rich plasma through the use of a centrifuge, and an injection of the platelet rich plasma under ultrasonic

guidance. As such, he found that the following CPT codes involve procedures similar to each step involved in the platelet rich plasma injection:

§ CPT 50390 - aspiration, representing the extraction of blood

§ CPT 36513 - apheresis, representing the separation of blood into components, isolating the platelets

§ CPT 27370 - representing injection of PRP into the knee

§ CPT 76942 - ultrasonic guidance for needle placement.

Mr. Hearn concluded that the total amount due is \$3,179.64.

This arbitrator has considered both fee audits and finds applicant's fee coder's analysis to be thorough and persuasive. Accordingly, applicant is awarded reimbursement in the amount of \$3,179.64. Attorney's fees shall be calculated pursuant to 11 NYCRR 65-4.6 (d). Interest shall be calculated from December 9, 2020, which is the AR1 filing date. See, 11 NYCRR 65-3.9 (c).

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	Amount Amended	Status
	Tim Canty M.D. PLLC	06/12/20 - 06/23/20	\$13,570.6 7	\$3,179.64	Awarded: \$3,179.64
Total			\$13,570.6 7		Awarded: \$3,179.64

- B. The insurer shall also compute and pay the applicant interest set forth below. 12/09/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

See, the within award.

C. Attorney's Fees

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

See, the within award.

- 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 New York
SS :
County of Nassau

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

10/17/2021
(Dated)

Pamela Hirschhorn

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:
5fa3211c2006f8baa477fbd6c0266dad

Electronically Signed

Your name: Pamela Hirschhorn
Signed on: 10/17/2021