American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Jules Francois Parisien MD (Applicant)	AAA Case No.	17-22-1240-0494
	Applicant's File No.	2354
- and -	Insurer's Claim File No.	602101969421
	NAIC No.	36587
Palisades Insurance Company (Respondent)		

ARBITRATION AWARD

I, Teresa Girolamo, Esq., 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: A.B.

1. Hearing(s) held on 06/27/2022
   Declared closed by the arbitrator on 08/12/2022

   Maria Shteysel, Esq. from Shteysel Law Firm, P.C. participated in person for the Applicant

   Kevin Oates, Esq. from Law Office of William J. Fitzula f/k/a Law Office of Patricia A. Palma participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$2,274.69**, was AMENDED and permitted by the arbitrator at the oral hearing.

   At the time of the Arbitration Applicant reduced the amount in dispute to $2,014.94 recognizing partial payment.

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

3. Summary of Issues in Dispute

   Whether Applicant is entitled to any recovery as Respondent contends that it paid as per fee schedule?

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the Electronic Case Folder as of the date of the hearing. This decision is based on my review of that file, as well as the arguments of the parties at the hearing. Each of the parties appeared via ZOOM.

As it was stipulated that Applicant has made out its *prima facie* case Respondent has the burden to rebut the claim with proof that the health care services were not medically necessary or with some other viable defense (See *Amaze Med. Supply v. Eagle Ins*. Co. 2 Misc. 3rd 128[A] 2003.

Once the 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).

On 2/24/2022 Applicant filed for Arbitration. The AR-1 lists two bills as follows:

Bill 1 $324.69 DOS 12/23/2021

Bill 2 $1,950.00 DOS 12/23/2021

Bill 1: This is an office billed under CPT Code 99244 in the amount of $324.69. The provider is Barbara Kerr, N.P.

Bill 2: Lists 6 charges under CPT Code 20999 each in the amount of $100 for dry needling and 18 charges for dry needling each in the amount of $75.00 for a total of $1,950.00. The provider is also listed as Barbara Kerr Nurse Practitioner.

The office report states under History, that the last recommendation/ Plan of care, "on the last visit, the following recommendations(s) were made, Physical Therapy, Medications, Orthotics, Chiropractor, acupuncture, and status "Moderate Improvement."

According to Respondent's submissions the office visit under CPT Code 99244 the payment of $259.75 was towards the office visit. In support of Respondent's defense, Respondent provided a Coder Affidavit of Kimberly Spahr, CPC, CPMA. Following a review of the medical records was of the opinion that the total amount in dispute should only be $104.81.

Respondent's Coder Affidavit:

Interestingly, Kimberly Spahr, CPC, CPMA, of Signet Claims Solutions, LLC. Who is a Certified Professional Coder and Certified Professional Medical Auditor.

Following a list of documentation provided, at page 2 of the fee audit, is a list of the charges and what is the correct reimbursement. For the office visit billed in the amount of $324.69 Kimberly Spahr, CPC, CPMA, states that there is no reimbursement.

For the Dry needling, Kimberly Spahr, CPC, CPMA, opines that for the first charge under CPT Code 20999 billed at $100.00, the proper code to bill is CPT Code 20561 and it is reimbursable in the amount of $100.00. For the second CPT Code billed under CPT Code 20999 in the amount of $75.00, Kimberly Spahr, CPC, CPMA states that there is no correct CPT Code and reimbursement is $4.81. For each of the remaining charges for Dry Needling, Kimberly Spahr, CPC, CPMA states that there is no reimbursement.

Rationale for non payment of office visit:

> *According to the guidelines, a Physician Assistant or Nurse Practitioner is not permitted to care for a new problem under the workers compensation program without discussing the findings in person or by telephone with a responsible physician prior to instituting treatment. No payment should be made for care provided by the PA or NP that does not meet this requirement.*
>
> *Research on line was done to determine the place of service and information regarding a supervising physician. None were found. The 2nd Nurse Practitioner (Barbara Kerr, NP) states to be the provider service.*
>
> *The services rendered have documentation that does not support the requirements for the Nurse Practitioner to report under NYS WC Medical Guidelines. No statement regarding physician or physician discussion, who would be responsible for the medical services, is noted in the documentation of the services. The services are also allowed to be billed under the Nurse Practitioner.*
>
> *Notice of a request for consultation to the Nurse Practitioner for care from the primary provider is also required for the consultation services.*
>
> *Prior to reimbursement, physician responsibility should be established, as it is required in the documentation. A stated request for consultation should also be available in the medical record for documentation requirements.*

At page 4/8 of the fee audit, Kimberly Spahr, CPC, CPMA continues, that if the criteria above is met, there still is no payment under CPT Code 99224 as it is a consultation code that is by a physician…

As the services were rendered by a Nurse Practitioner under the New ground rules as of 10/1/2020 Kimberly Spahr, CPC, CPMA noted the following:

> *The supervising physician must render the bill for care, with the ensuring payment for the PA or NP service made directly to the supervising physician. Such bill shall include the modifier NP or PA to identify nurse practitioner or physician assistant and include both names of the supervising physician and NP or PA. When an NP or PA is employed by the facility where the service was performed the bill may be signed by the facility representative at 80% of the supervising physician fee.*

> *Provider does not offer any indication of whether patient was a new patient or established patient with a new problem, or where the consult request came from*

With respect to the CPT Code 20999, Kimberly Spahr, CPC, CPMA notes that Applicant billed 24 times under CPT Code 29999, with and without modifier 59, for "dry needling" services on 12/23/2021".

Kimberly Spahr, CPC, CPMA states, the following:

Unlisted codes are limited to one per date of service/visit/episode of care. The code is not reported over and over for different or same services. Since the code does not describe a specific procedure or service, it is important to have supporting documentation. The unlisted codes do not include descriptor language that specifies the components of a service.

At page 6/8 of the coder Affidavit Kimberly Spahr, CPC, CPMA states:

The provider billed in the amount of $1,950.00 on 12/23/2021 for CPT Code 20999 (equivalent to 7.74) RVU; obtained by dividing the amount billed by the conversion factor of $251.94). This is NOT maintaining relative consistency within the code set.

With respect to Dry Needling, Kimberly Spahr, CPC, CPMA states " dry needling" is not comparable to a trigger point injection. In a trigger point injection, medication/drug is injected whereas in "dry needling" no drug/ medication is given.

> *As of 10/1/2020, providers are allowed to use the new NYS WC Medical Fee Schedule codes and fees. This will affect date of service 10/15/2020 Two codes were added to the code set for Dry needling*

> *CPT Code 20560 - Needle insertion(s) without injection(s) 1-2 muscles*

> *CPT Code 20561 - Needle insertion (s) without injection(s) 3 or m ore muscles.*

To provide value, there is no true code exact to the services rendered; however, the value of CPT code 20553 would be the best comparison code - without the injectable, which would be a separate fee for medications anyway.

CPT Code 20553 - Infection(s) single or multiple trigger point(s) 3 or more muscles.

This code is reported for 3 or more muscles only, not per injection/ dry needle.

At page 7/8 of the peer report Kimberly Spahr, CPC, CPMA, calculates that the Conversion factor for this provider, within the region for Surgery services is $251., RVU (relative value unit) is based on each code.

CPT Code 20561 - $251.94 x .52 - $131.01 x 80% = $104.81.

Having reviewed Respondent's evidence I find the Coder Affidavit has established that the amount of recovery should be no greater than $104.81 as such Applicant has the burden to rebut same.

Applicant's Coder Affidavit:

Applicant offers a "Fee Schedule Affidavit" of Olesya Malyuta, who states that she is a certified coder under Certificate of N6N9D4S3. Ms. Malyuta, opines that Kimberly Spahr's analysis of CPT Code 20999 is erroneous and that CPT Code 20553 should not be used.

Ms. Malyuta references various arbitration decisions, however, I find that these do not establish that Applicant properly billed.

Ms. Malyuta next addressed Ground Rule 10 of the surgery section regarding fee schedule for a By Report code.

Ms. Malyuta states that Needling was performed on more than one muscle. There is no disputing this. Ms. Malyuta states, that the "best code" to be used is CPT Code 20099.

Ms. Malyuta states that the codes of 20560, 20561, 20552 and 20553 are not correct as trigger points are different than dry needling.

I note that Ms. Malyuta does not address the fee schedule that went into effect in 2020.

Given the diverse positions taken, and with the consent of both Applicant and Respondent I requested an IHC Report. The following was requested:

IHC Request:

Specialty requested: Physical Medicine and Rehabilitation

Questions for IHC:

I need a coder affidavit as to whether or not Applicant billed properly for dry needling. Please review the 2 coder affidavits in this case, and all bills associated.

Documents to review:

NF-3 Medicals NF-10s both coder affidavits Please note same request is made on unrelated case of AAA 17-21-1228-8974

The request was made on this case as well as the case of 17-21-1228-8974 as the identical issues were presented.

IHC Report

The IHC Report was received and presented to me for consideration. In reviewing the original report, Susan Montana, COC, CPMA, CHTS-TR opined that the total recovery should be $104.80. As such, I requested that AAA ask the Coder whether or not that would be in addition to the office visit paid, or total recovery for the entire bill.

As such, a Revised Report was provided dated 7/27/2022. The additional request is noted on page 1:

7/27/22 additional information requested by Arbitrator:

The arbitrator would like to know the following:

- Whether or not the opinion of reimbursement of $104.80 for dry needling is in addition to the office visit that was reimbursed in the amount of $259.75.

- Is the payment for the office visit under CPT Code 99244 in the amount of $324.69 was in excess of fee schedule?

- Whether Respondent properly reimbursed that service in the amount of $259.75.

The IHC report next lists the documents under consideration. The analysis and findings start at page 2/6 with the following excerpts:

Summary

The proper fee reimbursement for all the services provided on 12/23/2021 is $104.80.

Analysis:

Susan Montana, CPC, CPMA, CHTS-TR disagreed with the Adjuster's EOB that disallowed the charges "*based upon a reference to the Chiropractic, Podiatry and Behavioral Fee Schedules. We find nothing in these Fee Schedules that are applicable to this case. Nurse Practitioner Kerr is not identified as one of those provider types. Therefore Ms. Araneo's disallowance is not supported*."

Susan Montana, CPC, CPMA, CHTS-TR also disagreed with Kimberly Spahr CPC, CPMA "*that a supervising authorized physician is required in order for a Nurse Practitioner to bill for services.*"

Relying on the 2018 NYS Worker's Compensation Fee Schedule Ground Rule #11, in effective on the date of services same states:

> *11. Ground Rules for Physician Assistants (PA) and Nurse Practitioners (NP)*
>
> *Authorized Nurse Practitioners who render care and treatment in accordance with their scope of practice under State Education Law, and Physician Assistants who render treatment and care for ongoing temporary disability in accordance with the Workers' Compensation Law, shall report and bill using their individual authorization numbers and bills shall be payable at 80 percent of the fee available to physicians for such treatment code.*

Susan Montana, CPC, CPMA, CHTS-TR disagreed with Applicant's fee schedule by Olesya Malyuta wherein Ms. Malyuta states she is a NYS licensed certified coder and provider a certification number. Susan Montana, CPC, CPMA, CHTS-TR states, "*New York state does not license medical coders, and the certification number provided does not appear on either the AAPC or AHIMA credential verification systems. Therefore, it is not clear to us that Ms. Malyuta is in fact a certified medical coder.*"

Susan Montana, CPC, CPMA, CHTS-TR notes that Ms. Malyuta cited redacted cases, but also notes as I noted in my review that Ms. Malyuta did not address the brand-new code for dry needing as of 1/1/2020.

Moreover, Susan Montana, CPC, CPMA, CHTS-TR states as I also noted that there is no support offered for billing $75-100 per muscle.

In formulating the opinion, Susan Montana, CPC, CPMA, CHTS-TR states that the documentation submitted does not support the codes reported on the NF-3.

There are three CPT codes addressed by the provider and fee coders:

20553 Injection(s); single or multiple trigger point(s), 3 or more muscles

20561 Needle insertion(s) without injection(s); 3 or more muscles

20999 Unlisted procedure, musculoskeletal system, general

CPT code 20561 was introduced by the AMA into the CPT code set in 2020. The New York State Workers' Compensation Medical Fee Schedule is based upon the 2018 CPT code set. Therefore, this code is not listed in the 2018 Surgery Fee Schedule.

Many CPT codes are subject to CMS Medically Unlikely Edits (MUE). An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All the codes referenced in this report contain an MUE value of 1, meaning multiple units are not reportable.

We find Ms. Malyuta's explanation of the procedure and proper coding/billing to be confusing and contradictory, indicating perhaps she is not familiar with the definitions of certain terms such as "session", or that perhaps her notes are cut/paste from random sources. For example, she states:

• *Most significantly, "in addition to muscle injection, needing was also performed." Muscle injection is a completely different procedure, and would be the primary procedure (see more detailed explanation below). [emphasis added]*

• *"Use of CPT code 20099 involves injection and needling of sheath, ligament, trigger point, which consists of injected into area to relax intense muscles. 20999 specify three or more muscle and treating physician must report these muscles injected."*

o 20999 (Unlisted procedure, musculoskeletal system, general) does not reflect any of the verbiage cited by Ms. Malyuta.

o We assume the first mention of 20099 is a typographical error

• "Injections and needling are per session codes, no modifiers can be used." We note the NF-3 reports:

o One session was performed on 12/23/2021, as supported by the documentation

o Multiple lines of 20999 with modifier 59

Our review of the documentation identifies contradictions regarding the services provided. The document appears to be a preprinted form with a series of checkboxes and fill-in-the-blanks throughout the documentation, however, what we look for is a detailed description of the actual procedures performed. This is reflected on page 7 of NP Kerr's documentation and states:

"…each area/trigger point was injected with 0.5cc of 0.5% Marcaine via 3cc syringe with a 1-1/2 x 25G sterile hypodermic needle. Needling was performed to further break up the trigger points." [emphasis added]

This clearly describes a trigger point injection which would be the primary procedure code. 20553 Injection(s); single or multiple trigger point(s), 3 or more muscles would be the appropriate code for the trigger point injections. Regarding the dry needling, we note the AMA CPT code book, which provides additional guidance on the proper use of the code set, contains a clarification beneath the description of CPT code 20553 which states:

Do not report 20552, 20553 in conjunction with 20560, 20561 for the same muscle(s).

This is further supported by consulting the National Correct Coding Initiative (NCCI) edit tables. The NCCI Edit table entries identify inclusive procedures, meaning they are not separately reportable….

Susan Montana, CPC, CPMA, CHTS-TR concurs with Ms. Spahr's opinion regarding CPT Code 99244, as in this case there is no indication that the consultation was requested by another physician, which is a requirement for CPT Code 99244.

Hereto, Susan Montana, CPC, CPMA, CHTS-TR points out as I indicated above, that the report references, "*last recommendation/ plan of care*", documents that recommendations of physical therapy, medications, orthotics, chiropractor and acupuncture treatment was previously recommended and that there was moderate improvement.

As such, when a "consultation" that is not requested by a physician or other appropriate source, may be reported using an office code of CPT 99212; 99213; 99214; 99215.

We were not provided with a 1500 Claim Form, which typically represents the details of the services billed, so we rely on the NF-3 Forms provided for our review. It is unclear why two separate NF-3 forms were submitted, however, typically all services rendered by a provider on the same date of service are reported together. Had these services been billed properly, the E/M service would have been reported with a modifier 25 since that is the only way it could have been considered for payment based upon the NCCI edit tables.

• Without the modifier, the E/M service is not reportable.

• With a modifier, the service is not supported.

Therefore in conclusion Susan Montana, COC, CPMA, CHTS-TR opines as follows:

Therefore, we calculate the reimbursement for all of the services provided by NP Kerr on 12/23/2021 as follows:

CPT	NYS WC RVU (Surgery)	Conversion Factor (Region II)	Fee Schedule Amount (x conversion factor)	80% of Fee Schedule Amount to NP
20553	0.52	$251.94	$131.00	$104.80

Applicant and Respondent's responses.

As is the procedure a copy of the IHC report was sent to both Applicant and Respondent for comments. Following the time period in which to respond, AAA notified me as Arbitrator that the case could now be closed. As such, on 8/12/2022 the matter was closed.

Applicant uploaded a certificate from the National Health Career Association, that Olesya Malyuta has successfully completed the requirements set forth by the NHA as a Certified Billing and Coder Specialist. It is difficult to read and is unclear as to what state this was issued in. The second copy os clear, with a Certification number, but again it is unclear if this is for New York State or not. Either way, it does not change the position of ***We find Ms. Malyuta's explanation of the procedure and proper coding/billing to be confusing and contradictory, indicating perhaps she is not familiar with the definitions of certain terms such as "session", or that perhaps her notes are cut/paste from random sources***.

Having reviewed the evidence carefully in this case, and having the benefit of the IHC report which I found extremely informative and educational, I, as the trier of fact, find that Applicant, for date of service of 12/23/2021 was overcompensated as such, no further recovery is warranted. Applicant's 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 Nassau

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

08/13/2022
(Dated)

Teresa Girolamo, Esq.

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
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Electronically Signed

Your name: Teresa Girolamo, Esq.
Signed on: 08/13/2022