

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Shernet Barrett
(Applicant)

- and -

LM General Insurance Company
(Respondent)

AAA Case No. 17-22-1240-0662

Applicant's File No. MB-86519

Insurer's Claim File No. 046404494-0004

NAIC No. 36447

ARBITRATION AWARD

I, Mitchell Lustig, 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

1. Hearing(s) held on 08/22/2022
Declared closed by the arbitrator on 08/22/2022

Law Offices of Mark Bratkovsky from Law Offices of Mark Bratkovsky PC.
participated in person for the Applicant

Steven Levy, Esq. from Callinan & Smith LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,385.94**, 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

In dispute is Applicant Shernet Barrett's claim as the assignee of a 32- year-old male injured in a motor vehicle accident on July 27, 2021, for reimbursement in the sum of \$1,385.94 for an office visit and dry needling performed by Shernet Barrett, NP on October 22, 2021.

The Applicant billed CPT Code 99215 for the office visit and CPT Code 20999 for the dry needling.

The Applicant's claim represents the difference between the amount of its bills (\$1,653.76) and the amount reimbursed by the Respondent (\$267.82)

The Respondent partially denied the claim based upon the grounds that the Applicant billed in excess of the fee schedule. Thus, the issue presented for my determination is whether the Respondent properly reduced the Applicants bills in accordance with the fee schedule.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the ADR Center. This decision is based upon the submissions of the parties and the arguments made by the parties at the hearing.

A health care provider establishes its prima facie entitlement to No-Fault benefits as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and that payment of No-Fault benefits were overdue. Westchester Medical Center v. Lincoln General Insurance Company, 60 A.D.3d 1045, 877 N.Y.S.2d 340 (2nd Dept. 2009). I find that the Applicant has established a prima facie case.

WHETHER THE INSURER HAS PROVEN THAT THE APPLICANT'S BILLS WERE IN EXCESS OF THE FEE SCHEDULE

An insurance carrier's timely asserted defense that the bills submitted were not properly no-fault rated or that the fees charged were in excess of the Workers' Compensation Fee Schedule is sufficient, if proven, to justify a reduction in payment or denial of claim. New York Hosp. Med. Ctr. Of Queens v. Country-Wide Insurance Company, 295 A.D.2d 583, 744 N.Y.S.2d 201 (2nd Dept. 2002); East Coast Acupuncture, P.C. v. New York Central Mutual Insurance, 18 Misc.3d 139(A), 2008 N.Y. Slip Op. 50344(U) (App. Term 2nd and 11th Jud. Dists. 2008); A.B. Medical Services, PLLC v. American Transit Insurance Company, 15 Misc.3d 132(A), 2007 N.Y. Slip Op. 50680(U) (App. Term 2nd and 11th Jud. Dists. 2007).

The insurer has the burden of coming forward with competent evidentiary proof to support its fee schedule reduction or denial. See, e.g., Roberts Physical Therapy, P.C. v. State Farm Mutual Automobile Insurance Company, 13 Misc.3d 172, 3006 N.Y. Slip Op. 26240 (N.Y. Civ. Ct. Kings Co. 2006).

In the absence of such proof, a defense of noncompliance with the appropriate fee schedule cannot be sustained. Continental Medical, P.C. v. Travelers Indemnity Company, 11 Misc.3d 145(A), 2006 N.Y. Slip Op. 50841(U) (App. Term 1st Dept. 2006).

I am permitted to take judicial notice of the Workers' Compensation Fee Schedule. See Kingsbrook Jewish Medical Center v. Allstate Insurance Company, 61 A.D.3d 13, 20 (2

nd Dept. 2009); LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), 2011 N.Y. Slip Op. 51721(U) (App. Term 2nd, 11th and 13th Nudists. 2011); Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A), 2011 N.Y. Slip Op. 50040(U) (App. Term 1st Dept. 2011).

In support of its contention that the Applicant billed in excess of the fee schedule, the Respondent submitted a fee audit dated March 30, 2022 from its certified fee coder, Gina Ball, CPC. In her fee audit, Ms. Ball asserted that the Applicant was only entitled to the sum of \$267.82 for the office visit and dry needling performed by herein by NP Barrett. As specifically noted by Ms. Ball in her fee audit:

"Regarding code 20999 & 20999.59: Per the NYS Fee Schedule, code 20999-defined as unlisted procedure, musculoskeletal system, general, is a by report (BR) code, without an assigned RVU. Per Surgery Ground Rule #10, information concerning the nature, extent and need for the procedure or service, time, skill and equipment necessary, etc., is to be furnished using all of the following:

- A) Diagnosis (postoperative), pertinent history, and physical findings
- B) Size, location, and number of lesions or procedures where appropriate
- C) A complete description of the major surgical procedure and the supplementary procedures
- D) When possible, list the closest similar procedure by code and relative value unit. The "BR" relative value unit shall be consistent in relativity with other relative units in the schedule.
- E) Estimated follow-up period, if not listed.
- F) Operative time.

Provider documentation identifies service billed under code 20999 as "dry needling". Documentation supports services performed to 30 muscles. It appears that provider billed code 20999 per needling.

Carrier agrees that currently there is no NYS Fee Schedule code dedicated to dry needling; hence code 20999 may be reported. However, while code 20999 is an unlisted By Report code without an RVU, the provider failed to establish a similar RVU which is required by Ground Rule #10 noted above.

Specifically, the closest similar procedure by code and relative value was not listed. Again, the By Report value unit shall be consistent in relativity with other relative units in the schedule, and the provider failed to establish a similar RVU. The provider supplied no information as to how charges were derived and there is no evidence pricing to a similar service code.

Since there is no evidence of pricing to a similar service code but a service was performed, carrier assigns RVU at 0.52 equal to that of comparable code 20553 to code 20999(59), which is defined as: Injection(s); single or multiple trigger point(s), 3 or more muscle(s).

As above, code 20553 reflects injections to single or multiple trigger points to three or more muscles. Therefore, code is reimbursed once regardless of the number of injections or muscles injected. Please refer to the September 2003, Volume 13, Issue 9 of the AMA CPT Assistant for further explanation. (enclosure) Since the CPT Assistant is a publication of the AMA noted in the AMA CPT Book which is clearly referenced in the Fee Schedule, it is used as an applicable resource. Based on the same, code 20999 considered at one unit. Use of modifier 59 not applicable.

Per NYS Fee Schedule Introductions and General Guidelines, the Relative Value column lists the relative value units (RVU) used to calculate the fee amount for a service. Except as otherwise provided in the schedule, the maximum fee amount is calculated by multiplying the relative value units by the applicable conversion factor.

Services were rendered in Flushing, NY 11379 which falls under NYS Fee Schedule geographical region

IV. The conversion factor the surgery section for region IV is \$251.94 and for the E/M section is \$15.06.

Services were provided by Shernett Barrett, PA.

Per Fee Schedule General Ground Rule #11, "Ground Rules for Physician Assistants (PA) and Nurse Practitioners (NP)": "bills shall be payable at 80 percent of the fee available to physicians for such treatment code".

Summary:

Code 99215: \$163.01 RVU 13.53 x \$15.06 x 80%

Code 20999x1: \$104.81 RVU 0.52 x \$251.94 x 80%

Eligible amount due based on above review: \$267.82."

I find that Ms. Ball's fee audit is credible and persuasive.

In opposition, the Applicant submitted an Affidavit from Dr. Jules Parisien dated February 7, 2020 and an Affidavit from Olesya Malyuta, sworn to on July 1, 2022. In their respective Affidavits, Dr. Parisien and Olesya and Malyuta asserted that the Applicant properly billed in the sum of \$1,653.76 for the office visit and dry needling performed herein.

After careful consideration of the evidence, I am persuaded by Ms. Ball's fee audit and find that it is more credible and persuasive than the Applicant's rebuttal evidence. Since

the Respondent already reimbursed the Applicant in the sum of \$267.82, I find that the Applicant is not entitled to any additional reimbursement. See *Dorrett Bryan, NP v. LM General Insurance Company*, AAA Case No.: 17-22-1236-8308 (Arbitrator Mitchell Lustig, 7/8/2022).

I note that my decision is accord with my fellow arbitrators who have similarly found that Ms. Ball's fee audit was credible and persuasive. See *Wellberg NP In Family Health PLLC v. LM General Insurance Company*, AAA Case No.: 17-21-1219-5323 (Arbitrator Giovanna Tuttolomondo, 6/14/2022; *Minni Choi NP v. LM General Insurance Company*, AAA Case No.: 17-20-1183-8001 (Arbitrator Robyn McAllister, 11/8/2021). See also *Minnie Choi, NP v. LM General Insurance Company*, AAA Case No.: 17-20-1178-1369 (Arbitrator Meryem Toksoy, 4/15/2022).

Accordingly, the Respondent's denial is upheld and the 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, Mitchell Lustig, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

08/25/2022

(Dated)

Mitchell Lustig

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:
9271b2b94f3b1bd666e6f9e6c8d80521

Electronically Signed

Your name: Mitchell Lustig
Signed on: 08/25/2022