American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Excel Surgery Center, LLC (Applicant)	AAA Case No.	17-16-1038-7168
	Applicant's File No.	10032
- and -	Insurer's Claim File No.	140852-03
	NAIC No.	36030
Maya Assurance Company (Respondent)		

ARBITRATION AWARD

I, Kevin R. Glynn, 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 06/23/2017
   Declared closed by the arbitrator on 06/23/2017

   Koenig Pierre, Esq. from Korsunskiy Legal Group P.C. participated in person for the Applicant

   Christine Lee, Esq. from De Martini & Yi, LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 3,254.12**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   Respondent stipulated that Applicant established a prima facie case and Applicant stipulated that Respondent issued a timely denial.

3. Summary of Issues in Dispute

   The Assignor, VG, is a 49yo female passenger who was injured in a motor vehicle accident on 10/29/14. VG suffered injuries which resulted in her seeking treatment. In dispute are the Applicant's ancillary claims (anesthesia, ultrasonic guidance, nerve block injections) related to left shoulder surgery performed on 4/25/16. The claim was denied based on an Independent Medical Examination (IME) performed by Dr. Joseph

Margulies, M.D., on 2/20/15.Therefore, the issue in dispute is the medical necessity of these claims, and if necessary, the correct amount of reimbursement pursuant to the fee schedule.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the Parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived.

To support a lack of medical necessity defense Respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219(U) (App. Term 2d, 11th and 13th Jud. Dists. 2014). Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to Applicant. See generally, Bronx Expert Radiology, P.C. v. Travelers Ins. Co. 2006 NY Slip Op 52116 (App Term 1st Dept. 2006). The Appellate Courts have not clearly defined what satisfies this standard except to the extent that "bald assertions" are insufficient. Amherst Medical Supply, LLC v. A Central Ins. Co., 2013 NY Slip Op 51800(U) (App. Term 1st Dept. 2013). To rebut an IME report, and meet its burden of persuasion, Applicant must submit records or reports that are based on a contemporaneous examination of the patient that address or rebut the objective medical findings in respondent's report. See Arnica Acupuncture, P.C. v Interboard Ins. Co., 2016 NY Slip Op 01434 (App Term 1st Dept. 2016).

Respondent's evidence established that the claim was timely denied pursuant to the IME by Dr. Joseph Margulies, M.D., performed on 2/20/15. Dr. Margulies performed a thorough examination of the medical records involving the assignor's left shoulder as well as a physical examination of the left shoulder. He documented the examination results regarding the left shoulder as follows:

> Full glenohumeral motion in the shoulders. Range of motion of the shoulders reveal anterior flexion to 170 degrees (170 degrees normal), abduction to 180 degrees (180 degrees normal), adduction to 45 degrees (45 degrees normal), external rotation to 90 degrees (90 degrees normal), internal rotation to 80 degrees (80 degrees normal) and posterior extension to 45 degrees (45 degrees normal). I observed no evidence of rotator cuff disease, as the Speed's test and drop arm test are negative. No

> instability to the Fulcrum or jerk test noted. The impingement signs in both Hawkins and Neer are negative.

Furthermore, he diagnosed the assignor as having a resolved left shoulder contusion and opined that "from an orthopedic standpoint, there is no need for further treatment."

Respondent demonstrates a medical rationale and factual basis to support its defense that the services rendered were not medically necessary. Accordingly, the burden now shifts to Applicant, who bears the ultimate burden of persuasion. See, Bronx Expert, supra.

Applicant submits a rebuttal report by Dr. Mark Kramer, M.D., dated 5/9/17. Dr. Kramer begins by refuting the findings of the IME report, stating specifically that:

> On 12/10/2014 VG presented to me with complaints of left shoulder pain and decreased range of motion with positive Hawkins and Neer's test. Based upon clinical evaluation and physical examination, I recommended right shoulder arthroscopy.
>
> Despite receiving conservative treatment for an extended period; the patient did not find true improvement in her complaints of left shoulder pain. VG then presented to me on 3/18/2016 for a follow up consultation. At that time, she complained of left shoulder pain rated at 10/10. The left shoulder pain was worse with overhead activity and carrying heavy objects. Examination of the left shoulder revealed tenderness on palpation over anterior aspect with positive Impingement Sign, decreased muscle strength and limited range of motion. The diagnosis made was left shoulder impingement. I recommended physical therapy and discussed left shoulder arthroscopy. After understanding all risks and benefits of the injection, the patient agreed to proceed with surgery.
>
> On 4/25/2016, the patient presented to me for scheduled left shoulder arthroscopy at Excel Surgery Center. The pre-operative diagnosis made was rule out rotator cuff and labral tear. The post-operative diagnosis was type I labral tear marked synovitis, bursitis, impingement and capsulitis.
>
> Based upon the patient's continued complaints of left shoulder pain, positive examination results, diagnostic test findings and the resulting diagnosis, the left shoulder arthroscopy was medically necessary for the treatment of VG's injuries.

In Orthopedic IME report of Dr. Joseph Margulies dated, 2/20/2015, Dr. Margulies acknowledged that the patient sustained injury to her neck back left shoulder and knee at the time of MVA. He observed pain in left knee and complaint of difficulty in bending, lifting, and sleeping at the time of IME. Dr. Margulies diagnosed clinically resolved sprain of the cervical spine, and left shoulder contusion and concluded that there was no need of physical therapy, diagnostic testing, prescription medication, special transportation household help or durable medical equipment.

I find Dr. Margulies' IME report incorrect and unreliable based on the following discussion:

First, it should be noted that Dr. Margulies has nowhere denied future need of surgery in his report. Hence, his report is not held valid to deny the medical necessity of the disputed left shoulder surgery.

Second, though the IME physician noted all normal findings; the post IME orthopedic evaluation performed by me on 3/18/2016 revealed left shoulder pain along with tenderness to the anterior aspect of the shoulder, decreased range of motion, diminished muscle strength and positive impingement sign. These findings prove that the patient's left shoulder condition was not resolved at the time of IME and she required further treatment till her condition is fully resolved.

Third also the operative report of the left shoulder arthroscopy documented evidence of type I labral tear, synovitis, impingement, and bursitis. These post-operative findings confirm that the patient's injuries were not resolved at the time of IME and the normal findings noted by IME physician were incorrect and biased in the interest of the insurer.

Also, the IME physician cannot get an accurate picture of a patient's overall condition without considering all subsequent exams, which apparently is the case, as the IME report did not encompass any subsequent evaluations. A patient's condition can exacerbate subsequently, particularly as the IME report acknowledges a number of positive complaints and findings on exam.

Dr. Kramer concludes by stating that:

> As evident from the pre-operative evaluation as well as intra-operative findings, the patient's condition in this case was consistent with the above indications such as tear in labrum, synovitis, bursitis, impingement etc and therefore required the left shoulder surgery.
>
> Based on the abovementioned discussion, it is my opinion that the patient was in need of Left Shoulder Arthroscopic Surgery performed on 4/25/2016 for treatment of her chronic pain. Since the procedure was medically necessary; all the associated services required for the performance of the procedure were medically necessary too. Therefore, I conclude that the fees charged for performing the procedure do not violate medical protocol and deserve to be reimbursed.

I find this rebuttal affirmation and the medical records in evidence to be sufficient proof to rebut the IME report and to establish the medical necessity of the surgery. Dr. Kramer first saw the Assignor in December of 2014 at which time she had complaints left shoulder pain with reduced ranges of motion and positive Hawkins and Neer's test. The assignor continued to receive conservative treatment until seeing Dr. Kramer again on 3/18/16, with complaints of pain rated at 10/10. He performed an examination of the Assignor, which revealed positive findings. He also presents a standard of care set forth by the NIH Guidelines and establishes that he met such standard. Although Dr. Margulies did document negative objective findings regarding the left shoulder at his 2/20/15 IME, the condition of the Assignor can 'wax and wane' after a motor vehicle accident, and therefore a prior finding at IME does not conclusively prove that later treatments were not medically necessary. See Huntington Med. Plaza, P.C. v. Travelers, 43 Misc. 3d 129(A) (App Term 2 Dept., 2014). Applicant's proofs are sufficient to support the position that the services provided to the assignor after the IME cut-off date were medically necessary. Accordingly, I find in favor of Applicant.

Fee Schedule

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip Op 26240, 12 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that an Applicant's claims were in excess of the appropriate fee schedule, Respondent's defense of noncompliance with the appropriate fee schedule cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y.Misc. LEXIS 1109 (App. Term, 1st Dep't, per curiam, 2006).

In support of its defense that the fees charged exceed the amount allowed under the fee schedule, Respondent submits the affidavit from Dr. James S. Lee, DC, CPC, dated 8/26/16. Dr. Lee sets forth his unrebutted opinion that:

The records indicate that the services were performed outside the State of New York. Therefore, pursuant to 1 1 NYCRR 68.6, "the permissible charge, shall be the prevailing fee in the geographic location of the provider." Excel Surgery Center, LLC, lists a Hackensack, NJ 07601 geographic location on its records. The prevailing in that location is the New Jersey PIP fee schedule pursuant to NJAC 1 1:3-29. Specifically, for this provider at zip code 07601, the North Region ambulatory surgery facility ("ASC") rates apply per NJAC 1 1:3-29.3. Per NJAC 1 1

"ASC facility fees are listed in Appendix, Exhibit 1, by CPT code. Codes that do not have an amount in the ASC facility fee column are not reimbursable if performed in an ASC.

Further, NJAC 11:3-29.4(e)(3) specifically states: "Codes in Appendix, Exhibit I that do not have an amount in the ASC facility fee column are not reimbursable if performed in an ASC and are not subject to the provision in (e) above concerning services not set forth in or covered by the fee schedules." As such, codes that do not have an amount in the ASC facility fee column are not reimbursable if performed in an ASC. The ASC facility fee includes services that would be covered if the services were furnished in a hospital on an inpatient or outpatient basis, including: (7) anesthesia materials, including the anesthetic itself, and any materials, whether disposable or re-usable, necessary for its administration. Per NJAC 11 3-29.5(d), when multiple procedures are performed in an ASC, the procedure with the highest payment amount is reimbursable at 100% and the additional procedures are reimbursable at 50% of the applicable fee. A procedure performed bilaterally in one operative session is reported at 150% as one payment amount, then ranked with the remaining procedures for the application of the appropriate multiple surgery reductions. Add-on codes are exempt from this rule and are reimbursable at their full fee. Per NJAC 1 1 :3-29.4(g), the fee schedules shall be interpreted in accordance with the Medicare Claims Processing Manual, the NCCI Policy Manual for Medicare services, Modifier 59 Article: Proper Usage Regarding Distinct Procedural Service, and the CPT Assistant. CPT code 01630 for anesthesia does not appear for North Region ASC's in the New Jersey fee schedule, Appendix, Exhibit 1, Physicians and ASC Fee Schedules. Per NJAC 1 1 :3-29.4(e)3 and NJAC 11:3-29,5(a), it is not separately reimbursable. Further, it is included in the global facility fee per NJTAC 1 1 :3-29.5(a)7. If the physician had billed

for these services instead of the ASC facility, the doctor would be reimbursable according to the New Jersey fee schedule for North Region physicians, Specifically, in 2016, the conversion factor for anesthesia units as pertaining to physicians in the North Region is $86.47. The A/B MAC computes time units by dividing the reported anesthesia time by 15 minutes and rounding the time units to one decimal place. The documented anesthesia time is 12:45 - 13:54, or 69 minutes. 69 minutes / 15 minutes = 4.6, which is rounded up to 5 time units. Medicare assigns 5 base units. Therefore, the anesthesiologist is reimbursable for 10 total units at $86.47 x 10 = $864.70. CPT code 76942 does not have a listed fee for North Region ASC's in the New Jersey fee schedule, Appendix, Exhibit 1, Physicians and ASC Fee Schedules. It instead has an NI payment indicator, which states "ASC packaged procedure no separate payment." As such, this code is not separately reimbursable. If the physician had billed for these services instead of the ASC facility, the doctor would be reimbursable at the North Region physician amount of $334.15. CPT code 64415 has a listed fee of $517.89 for North Region ASC's in the New Jersey fee schedule, Appendix, Exhibit 1, Physicians and ASC Fee Schedules. However, the provider is limited to the billed amount of $304.12. Conclusion: Based on my review, the claim totaling $3,254.12 exceeds the permissible amount. The maximum reimbursable amount to the ASC facility is $304.12. An additional $1,198.85 would be due to physician for CPT codes 01630 and 76942. See the applicable sections of' the New Jersey fee schedule and other reference materials annexed to this affidavit.

Dr. Lee has set forth a sound and reasoned explanation that Applicant's claims exceed that allowed under the fee schedule, and that the proper reimbursement allowed under the fee schedule is $304.12, for the nerve block injections. As such, Applicant is awarded $304.12, and the remaining amount at issue is denied with prejudice as not being permitted under the applicable fee schedule.

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**
	Excel Surgery Center, LLC	**04/25/16 - 04/25/16**	**$3,254.12**	**Awarded: $304.12**
Total			**$3,254.12**	**Awarded: $304.12**

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 07/14/2016, which is a relevant date only to the extent set forth below.)

Interest on the above-awarded amount shall be computed and paid at a rate of 2% per month, simple, commencing on the date the claim was filed in arbitration and ending with the date of payment of the award.

C. Attorney's Fees

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

An attorney's fee of 20% shall be paid on the sum of the awarded claim plus interest, subject to a maximum of $1,360.

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

06/30/2017
(Dated)

Kevin R. Glynn

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:
b173952833c0ced28f0081c56e3009aa

Electronically Signed

Your name: Kevin R. Glynn
Signed on: 06/30/2017