

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

RES Physical Medicine & Rehab. Services
(Applicant)

- and -

Allstate Property and Casualty Insurance
Company
(Respondent)

AAA Case No.

Applicant's File No.

Insurer's Claim File No.

NAIC No.

17-15-1023-3504

008-15-753

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ARBITRATION AWARD

I, Kent Benziger, 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: M.P.

1. Hearing(s) held on 06/30/2017
Declared closed by the arbitrator on 06/30/2017

Nicole Jones, Esq. from The Morris Law Firm, P.C. participated by telephone for the Applicant

Robert Quinn, Esq. from Allstate Property and Casualty Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 524.93**, 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

1) Whether the Applicant, RES Physical Medicine & Rehab Services, has made a prima facie showing of necessity for two treatment sessions on July 23, 2015 and August 25, 2015 that primarily involved drug screens and office evaluations; 2) Whether the Applicant is permitted to bill for a total of 13 units of a toxicology/drug screens under CPT 80101 on a given session; 3) Whether the Respondent has established lack of medical necessity for treatment as of July 24, 2015 based on the independent medical exam of Dr. Louis Nunez.

This hearing was conducted using the electronic case folder maintained by the American Arbitration Association. All documents contained in that folder are made part of the records of this hearing. I have reviewed the documents contained in the electronic case folder as of the date of this award as well as any documents submitted upon continuance of the case. Any documents submitted after the hearing that have not been entered in the electronic case folder as of the date of this award will be listed immediately below and forwarded to the American Arbitration Association at the time this award is issued for inclusion in said case folder.

4. Findings, Conclusions, and Basis Therefor

In this proceeding, the Applicant/Provider, RES Physical Medicine & Rehab Services, is seeking reimbursement for two sessions of treatment that primarily involved toxicology screening. The first session involves a fee schedule dispute on whether the Applicant is permitted to bill for multiple units of a toxicology drug screen under CPT 80101. The Respondent denied reimbursement for the second session based on the independent medical exam of Dr. Louis Nunez.

On February 4, 2015, the Assignor/Eligible Injured party, a 71-year-old female, was, by history, involved in a motor vehicle accident. Following the accident, the Assignor was evaluated at Sister's Hospital's emergency room for complaints of cervical and lumbar strain/sprains. The Assignor signed an Opioid Pain Management Agreement. The treatment included medication with toxicology screens. The Assignor was prescribed Zanaflex and Hydrocodone.

On July 23, 2015, the Applicant billed for an office consultation (CPT 99213, \$51.54), a toxicology screen with 12-units pursuant to CPT 80101, \$248.40) which is defined as a Drug Screen qualitative - "single class method (e.g. immunoassay, enzyme assay), each drug class". A Creatinine Blood test (CPT 82570, \$9.86), and a PH Body Fluid (CPT 83986, \$6.51) were also billed.

The Respondent reimbursed all of the services except only reimbursed five units of the total of 13-units billed under CPT 80101. The basis of the partial payment was stated as follows:

Units were reduced from 13 to 5 to reflect the actual number of drug classes per code description. Drug Classes were determined by DEA Classification. In addition to the foregoing reason for denial, the amount charged and sought to be reimbursed exceeds the amount permitted under the applicable Workers' Compensation Fee schedule and is not reimbursable as billed.

For all of the services the Respondent reimbursed \$171.02 which included a total of five units of CPT 80101 (four units under the bill for 12 units and one unit that was separately billed).

On August 25, 2015, the Applicant billed for the same services except for an outpatient exam under CPT 99214, \$74.79). The Respondent denied reimbursement pursuant to an independent medical exam from Dr. Louis Nunez.

On July 8, 2015, the Assignor was examined at the Respondent's request by Dr. Louis Nunez, an orthopedic. At the time of the exam, the Assignor complained of low back and right shoulder pain of 9/10. On examination, the Assignor had the following ranges of motion in the cervical spine: forward flexion -5/55, extension - 5/45, side bending -5/45, axial rotation -15/80. Dr. Nunez indicated that when he observed the Assignor informally, she was noted to move her head and neck to greater ranges of motion. The Assignor had full range of motion in the right shoulder for a person in this age group with forward flexion -160/180, abduction -160/180 rotation -80/80 with negative Hawkins and Neer Impingement sign, negative O'Brien's negative Can test. In the standing position, lumbar range of motion included forward flexion -25/60, extension -5/25, side bending left -10/45, right -10/45 and axial rotation -16/60 bilaterally. Straight leg raising caused back pain at 15 degrees on the right and 30 degrees on the left. The diagnoses included right shoulder contusion - resolved, MRI evidence that Dr. Nunez stated was of age-appropriate pathology and aggravation of pre-existing cervical and lumbar spina pathology - resolved. Dr. Nunez found no need for further treatment in his specialty of orthopedic surgery as well as no need for further physical therapy. He further noted that although there was reduced range of motion, the Assignor moved throughout the room with no abnormal gait and that pre-existing pathology would also restrict her motion. Based on the examination, the Respondent terminated further orthopedic, physical therapy, physical medicine and rehabilitation, massage therapy, pain management, prescription medication effective July 24, 2015.

Analysis. A presumption of medical necessity attaches to a Respondent's admission of the Applicant's timely submission of proper claim forms, and the burden then switches to the Respondent to demonstrate the lack of medical necessity. Acupuncture Prime Care, P.C. v. State Farm Mutual Auto Ins., 2007 N.Y. Slip Op. 522273U; 2007 N.Y. Misc. LEXIS 7860 (Dist. Ct. Nassau Co. 12/3/2007); A.B. Medical Services, PLLC v. N.Y. Central Mutual Fire Ins. Co., 7 Misc. 3d 1018(a), 801 N.Y.S.2d 229 (Civil Ct. Kings Co. 2005); Citywide Social Work & Psychological Services v. Travelers Indemnity, 3 Misc.3d 608, 609 (Civil Ct. Kings Co. 2004). Respondent thus bears "both the burden of production and burden of persuasion with respect to the medical necessity of the treatment or testing for which payment is sought". See: Bajaj v. Progressive Ins. Co. 14 Misc.3d 1202(A) (N.Y.C. Civ. Ct 2006). The quantum of proof necessary to meet Respondent's burden, at the bare minimum, is to "establish a factual basis and medical rationale for the lack of medical necessity of Applicant's services. Id. See also: A.B. Medical Services, supra. As to treatment including chiropractic care, the Respondent must document that the treatment was no longer benefiting the claimant and

was not providing curative or significant and quantifiable palliative benefits. *Hobby v. CNA Ins. Co.*, 267 A.D.2d 1084, (4 Dept., 1999).

As finding of fact, Dr. Nunez' examination is not persuasive. Dr. Nunez found limited range of motion. He then opined that the Assignor did move well in the room when not being tested but then acknowledged that there was pre-existing pathology that restricted her motion. Even if this is the case, exacerbation of pre-existing conditions are covered by the No-Fault law. *Kingsbrook Jewish Medical Center v. Allstate Insurance Co.*, 61 A.D.3d 13 (2d Dept. 2009). Further, the MRI studies did note central disc protrusions and an annular tear. These findings were not adequately discussed by the Dr. Nunez. The reports from an independent medical examination must contain not only the results of a physical examination, but also incorporate, discuss and review the patient's medical history including all positive clinical and diagnostic findings. *Carle Place Chiropractic v. New York Central Mut. Fire Ins. Co.*, 19 Misc.3d 1139(A), (Dist. Ct. Nassau Co., Andrew M. Engle, J., May 29, 2008). In sum, the Respondent has failed sustain its burden of proof. . *Nir v. Allstate Insurance Company*, 7 Misc.3d 544, 546, 547 (2005).

In the future, the Respondent may consider a closer examination of Dr. Strut's report to determine if the reports from successive treatment dates contain the exact same language to the extent that the sections could be deemed copied from earlier entries. However, this issue was not raised and the burden is on the Respondent who failed to sustain its burden. Applicant is awarded reimbursement.

Fee Schedule. Pursuant to the Fourth Amendment effective April 1, 2013 to 11 NYCRR 65-3.8(g)(1), the Applicant's fees cannot exceed the charges permission be pursuant to the Insurance Law 5108 which would incorporate the Workers Compensation Fee Schedule.

In support of its fee schedule defense, the Respondent has included the applicable portions of the New York Workers' Compensation Fee Schedule, Drug Enforcement Administration Fact Sheets, Controlled Substance Schedules and the Master Arbitration Awards including RES Physical Med. & Rehab Services v. Allstate, 99-15-1008-9219 (Master Arbitrator Robert Trestman (May 10, 2017); and, RES Physical Medicine & Rehab Services v. Allstate, AAA Case No. 99-14-9025-4961 (Master Arbitrator Anne L. Powers, November 28, 2016).

Respondent's counsel has cited DEA regulations applicable to the description of CPT 80101 to reflect the actual number of drug classes per code description. This assertion is based on a plain reading of the New York Workers' Compensation Fee Schedule. In addition, numerous arbitrators have previously ruled that CPT 80104 was incorporated into the fee schedule in 2011 for drug-testing for multiple classes of drugs. Ground Rule 12 of the Pathology and Laboratory section of the New York State Workers' Compensation Fee Schedule states:

;

When urine drug screening is performed in an office setting using a quick or rapid screening test method utilizing a stick/dip stick, cup, or similar device reimbursement shall be limited to one unit of 80101 for a single drug class or 80104 for two or more drug classes regardless of the number of drug classes tested or reported per date. The documented cost of the testing device per invoice may be reported (bill as CPT code 99070). In addition, the provider may bill the appropriate evaluation and management code commensurate with the services rendered.

As per AMA CPT Assistant 2010, CPT 80101 should be used for years prior to 2011 when running multiple tests at once. As of 2011, new code 80104 was implemented to be used when "assaying multiple drugs simultaneously due to a kit design". Arguably, this would have been the proper code.

In RES Physical Medicine & Rehab. Services, AAA Case. NO. 99-15-1008-9219 (May 10, 2017) Master Arbitrator Robert Trestman upheld the lower arbitrator's determination that Ground Rule 12 of the Pathology and Laboratory fee schedule was applicable and limited reimbursement to one unit of 90101 for a single drug class and found Dr. Strut's affidavit insufficient to rebut the applicability of Ground Rule 12 defense. The Master Arbitrator stated:

... as the arbitrator's fee schedule determination appears to be a rational fact finding that the subject testing falls under the definition and billing limitations of Ground Rule 12. Regarding applicant's contention as to the arbitrator's other "contradictory" awards, I find those cases distinguishable as the insurer stipulated to the amount of the bill/fee schedule or the arbitrator therein found that the insurer did not raise or adequately establish a fee schedule defense. In fact, my review of this arbitrator's awards and other arbitrator's awards and master arbitrator awards affirming those awards reveals the same Ground Rule 12 determination wherein the arbitrators found that the insurer preserved and established a fee schedule defense. [See 17-15-1008-9242; 17-15-1006-3144; 17-14-9052-9361; 17-14-9023- 8527 aff'd at 99-14-9023-8527; 17-14-9021-8866 aff'd at 99-14-9021-8866; 17-14-9025- 4961 aff'd at 99-14-9025-4961].

Master Arbitrator Anne L. Powers RES Physical Medicine & Rehab Services v. Allstate, AAA Case No. 99-14-9025-4961 (November 28, 2016) similarly upheld the lower arbitrator's determination that Ground Rule 12 applied and that there was no evidence

that this was not a quick or rapid screening test method and that the Applicant could only bill for one unit. See also: Nationwide AAA Case No. 17-14-9022-7403 (Feb. 5, 2016).

However, even though the Respondent submitted extensive persuasive authority that the Applicant can only bill CPT 80101 once per a session, the Respondent reimbursed for five units on July 23, 2015 "to reflect the actual number of drug classes per code description". Therefore, even though this arbitrator has ruled in prior awards that an Applicant is limited to reimbursement for one unit of CPT 80101 on a given date, as the Respondent on an earlier date awarded for five units on July 23, 2015, this arbitrator is constrained to award for five units on August 25, 2015 (\$103.50) as well as for additional services provided on that date: CPT 99214 - \$74.79, CPT 82570 - \$9.47 and CPT 83986 - \$6.51. Applicant is awarded reimbursement of \$194.27. Again, no further reimbursement is awarded as to the earlier July 23, 2015 date.

Interest. The insurer shall compute and pay to the Applicant the amount of interest from the filing date of the Request for Arbitration, at a rate of 2% per month, simple interest (i.e. not compounded) using a 30-day month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

Attorney's Fees. As said case was filed on or after February 4, 2015, Applicant is awarded attorney's fees for the total amount of first party benefits awarded. Pursuant to 11 NYCRR 65-4.6(c)(e), the Applicant is awarded 20 percent of the amount of the first party-benefits, with no minimum fee and a maximum \$1,360.00 which is the total amount awarded one Applicant in one action from one provider. See: LMK Psychological Services, P.C. v. State Farm Mut. Auto Ins. Co., 46 A.D.3d 1290; 849 N.Y.S.2d 310 (3 Dept. 2007).

APPLICANT IS AWARDED REIMBURSEMENT OF \$194.27, TOGETHER WITH INTEREST AND ATTORNEY'S FEES.

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
	RES Physical Medicine & Rehab. Services	07/23/15 - 08/25/15	\$524.93	Awarded: \$194.27
Total			\$524.93	Awarded: \$194.27

- B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 11/24/2015, which is a relevant date only to the extent set forth below.)

Interest. The insurer shall compute and pay to the Applicant the amount of interest from the filing date of the Request for Arbitration, at a rate of 2% per month, simple interest (i.e. not compounded) using a 30-day month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

- C. Attorney's Fees

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

Attorney's Fees. As said case was filed on or after February 4, 2015, Applicant is awarded attorney's fees for the total amount of first party benefits awarded. Pursuant to 11 NYCRR 65-4.6(c)(e), the Applicant is awarded 20 percent of the amount of the first party-benefits, with no minimum fee and a maximum \$1,360.00 which is the total amount awarded one Applicant in one action from one provider. See: LMK Psychological Services, P.C. v. State Farm Mut. Auto Ins. Co., 46 A.D.3d 1290; 849 N.Y.S.2d 310 (3 Dept. 2007).

- 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 Erie

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

07/26/2017

(Dated)

Kent Benziger

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:
9531236adb8231b965814494ea8f71ad

Electronically Signed

Your name: Kent Benziger
Signed on: 07/26/2017