American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Lefcort MUA Chiropractic, PC (Applicant)	AAA Case No.	17-16-1039-7744
	Applicant's File No.	4637634
- and -	Insurer's Claim File No.	0234358174 2CC
Allstate Property and Casualty Insurance Company (Respondent)	NAIC No.	17230

ARBITRATION AWARD

I, Michael B. Parson, 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: GS

1. Hearing(s) held on 10/09/2017
   Declared closed by the arbitrator on 10/09/2017

   Steven Super, Esq. from Super & Licatesi P.C. participated in person for the Applicant

   Brian Kratenstein, Esq. from Peter C. Merani Esq. participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 3,015.30**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The claim was amended to $1,521.69 to bring it into compliance with Applicant's view of the fee schedule and to withdraw the claim for an expert fee.

   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated to the timely service of all bills and denials.

3. Summary of Issues in Dispute

The issues to be determined are the medical necessity of manipulation under anesthesia (MUA) for which reimbursement was denied following an IME and global denial and, if medically necessary, whether Applicant's amended bill is in compliance with the applicable provisions of the New York Workers' Compensation Medical and Chiropractic Fee Schedules.

4. Findings, Conclusions, and Basis Therefor

GS, a female who was then 44 years old, was involved in an automobile accident on 2/6/12 while a passenger in a motor vehicle. She sustained various injuries and, on 5/8/12, attended an IME conducted by Corey Stein, DC. A global denial with an effective date of 5/25/12 ensued. The bills at issue cover an MUA performed by the Applicant's surgeon and co-surgeon on 7/27/12 and was specifically denied predicated on the IME.

***Prima Facie* Establishment of Entitlement to Reimbursement**

I note first that the face of the denials and the EOBs all indicate that the bills at issue were received by the Respondent on 8/28/12, with the denials dated 8/30/12.

Recently, the Court of Appeals reiterated what is required for a provider to establish its *prima facie* burden when it wrote, "[A] plaintiff demonstrates *prima facie* entitlement to summary judgment by submitting evidence that payment of no-fault benefits are overdue, and proof of its claim, using the statutory billing form, was mailed to and received by the defendant insurer." *Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co.*, 25 N.Y.3*d* 498, 501, 14 N.Y.S.3*d* 283, 286 (2015). This reiterates in no uncertain terms, that the initial burden remains as it was.

Respondent argues that the denial should not serve as a basis for the determination that Applicant met its initial burden. I disagree. The denial is the equivalent of a pleading in a court action in that it sets forth the defenses upon which the Respondent chose not to reimburse or to reimburse in a sum less than was billed. The denial, which also specifically notes the dates the bills were received, like any pleading, constitutes an admission of receipt and thus an admission that the Applicant's initial burden was met and that payments were not made as billed.

I find that the Applicant has met its *prima facie* burden.

Medical Necessity

My review of Dr. Stein's report of his IME reveals an examination that was thorough and completely normal. He diagnosed resolved lumbar sprain/strain. I find the IME report to clearly be facially sufficient to sustain Respondent's *prima facie* burden of establishing a lack of medical necessity for further orthopedic treatment and diagnostic testing.

In response, Applicant points to various reports and records, including the 5/18/12 report of physiatrist Bojun Chen, MD, a chiropractic examination of 5/18/12, a lower extremity EMG study of 3/6/12, and range of motion and muscle testing performed on 5/29/12. I find the totality of the records sufficient to meet Applicant's shifted burden of establishing medical necessity. Even thought the bulk of the evidence relied on by the Applicant does not involve a chiropractor, the findings of Dr. Chen and the various test results are sufficient to create a strong negative inference as to the credibility of the IME findings. Albeit two months prior to the IME, the EMG studies performed on 3/6/12 establish a lumbar radiculopathy at L5-S1 on the right and were suggestive of sensory nerve neuropathy bilaterally. It should be noted that GS underwent epidural steroidal injections (ESI) on 5/23/12 as well as prior to the IME. Dr. Chen found reduced lumbar range of motion at his examination on the same day as the IME, in spite of the previous ESI. Computerized range of motion and muscle testing on 5/29/12 indicate significant lumbar weakness and range of motion deficits, in contrast to Dr. Stein's findings. I find that the objective tests alone conclusively render the IME findings untrustworthy.

Accordingly, the denial is reversed.

Fee Schedule

The Applicant reported CPT codes 22505 (thoracic MUA), 22505 (Lumbar MUA), 27275 (Right Hip MUA), and 27275 (Left Hip MUA) for both the surgeon and co-surgeon. The surgeon reported modifier 59 for all four codes and the co-surgeon reported modifiers 59 and 62 for all four codes.

Applicant's amendment utilized the 50% reduction required by Surgery Ground Rule 5, effectively amending the use of modifier 59 to modifier 51. Applicant's amendment further utilizes Surgery Ground Rule 12 (B), calculating the co0surgeon's fee at 16% of that for the surgeon, effectively withdrawing its use of modifier 62.

The relative value (RV) for CPT code 22505 is .94 and the RV for CPT 27275 is 3.23. The Region IV conversion factor is $229.03. Region IV is where the procedure took place. Multiplying the RV by the conversion factor for CPT 27275 results in a fee of $739.77 for the most expensive procedure, with the Applicant having initially reported $739.80. The fee for lesser procedures, reported under CPT code 22505, prior to the 50% reduction mandated by GR 5, is $215.29. 22505 was reported at $215.30.

Respondent submitted the sworn fee audit of Imecca Welsh, CPC. Ms. Welsh agrees with the arithmetical results described in the previous paragraph. However, Ms. Welsh applies Surgery Ground Rule 12 (D), which is reflected by Applicant's initial use of modifier 62, *i.e.*, that two surgeons of equal skill were required to perform the MUA procedure, rather than an assistant and primary surgeon. GR 12 (D) requires proration of the entire allowable fee.

GR 12, modifier 62 and General Ground Rule 15 read as follows:

12. Concurrent Services by More Than One Physician

B) **Surgical Assistants:** Identify surgery performed by code number, appropriate modifier, and description of procedures. Assistants should bill at 16 percent of the code fee. The codes must coincide with those of the primary surgeon....

C) **Two surgeons:** Under certain circumstances the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical problem (e.g., urologist and a general surgeon in the creation of an ileal conduit). By prior agreement, the total value for the procedures may be apportioned by the providers in relation to the responsibility and work done. The total value may be increased by 25 percent in lieu of the assistant's charge. Under these circumstances, the services of each surgeon should be identified using the code number and appropriate modifier.

D) **Co-surgeons:** Under certain circumstances, two surgeons (usually with similar skills) may function simultaneously as primary surgeons performing distinct parts of a total surgical service (e.g. two surgeons simultaneously applying skin grafts to different parts of the body or to surgeons repairing different fractures in the same patient). By prior agreement the total value may be apportioned by the providers in relation to the responsibility and work done. The total value for the procedures shall not, however, be increased but shall be prorated between the co-surgeons. Under these circumstances, the services of each surgeon should be identified using the code number and appropriate modifier.

In the event of no agreement between co-surgeons, the proration shall be determined by a WCB Medical Arbitration Committee.

62. Two Surgeons

When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code (s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code....

General Ground Rules

15. Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. If more than one modifier is needed, place modifier 99 after the procedure code to

> indicate that two or more modifiers will follow. Some modifier descriptions in this fee schedule have been changed from the CPT language.

Ground Rule 15 then goes on to utilize the same language quoted above in modifier 62. Applicant reported modifier 62, which according to Ground Rule 15 of the General Guidelines of the fee schedule, refers to two primary surgeons. However, even though modifier 62 was reported, Dr. Lefcort reported the full allowable fee and Dr. Carnes reported one half for each reported CPT code. Clearly, use of modifier 62 and the nature of the performance of MUA, indicate that the two surgeons in this case were co-surgeons as defined in Surgery GR 12(D) and not, as urged by Ms. Welsh, governed by Surgery GR 12(B). In other words, I find that Ms. Welsh is incorrect in allowing the two surgeons to share 125% of the total allowable sums reportable. Here, I find that the surgeons are of equal skill and that the MUA requires two people of equal skills to perform the manipulations. There is no evidence of an assistant and there is no evidence of two surgeons as defined in GR 12(B). In fact, the operative report specifically lists both Dr. Lefcort and Dr. Carnes as having equal status with Dr. Lefcort's name appearing first. Since all the billing was in the name of the Applicant, the apportionment between the co-surgeons is not relevant.

Ms. Welsh also takes the position that CPT 22505, which is defined as "Manipulation of the spine requiring anesthesia, any region", may only be reported once. This is due to the fact that she reads the words "any region" as "all regions". This reading makes no sense. The plain language of the definition clearly refers to the ability of a surgeon to use the same CPT code for any region of the spine, *i.e.*, there is no difference in reporting for manipulation of the cervical, thoracic or lumbar spine. Here, there were two regions manipulated and thus I find two separate instances of 22505 were justified.

As such, I find that the Applicant was entitled to 100% of the full amount permitted for both surgeons together each CPT code reported, less 50% for each "lesser code" pursuant to Surgery GR 5. Therefore, the Applicant may recover $739.77 for the first instance of CPT 27275 and $369.89 for the second. It may also recover 50% for each time CPT 22505 was reported, for a total of $215.30 for that code, resulting in a total reimbursement of $1,324.96.

Accordingly, the denials are reversed to the extent set forth above.

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**
	Lefcort MUA Chiropractic, PC	**07/27/12 - 07/27/12**	**$2,865.30**	**$1,521.69**	**Awarded: $1,324.96**
Total			**$3,015.30**		**Awarded: $1,324.96**

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 07/27/2016, which is a relevant date only to the extent set forth below.)

Interest shall run from the above noted filing date and end on 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

Respondent shall pay an attorney's fee in accordance with 11 NYCRR 65-4.6 (d).

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 Suffolk

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

10/11/2017
(Dated)

Michael B. Parson

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:
54e0968567b47e12f9c05ad7cf4dbc46

Electronically Signed

Your name: Michael B. Parson
Signed on: 10/11/2017