

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Daniel Cox DC PC
(Applicant)

- and -

St. Paul Travelers Insurance Co.
(Respondent)

AAA Case No. 17-16-1035-1126

Applicant's File No. 16-4478

Insurer's Claim File No. HYA6052

NAIC No. 38130

ARBITRATION AWARD

I, Michelle Murphy-Louden, 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: EIP

1. Hearing(s) held on 02/15/2018
Declared closed by the arbitrator on 02/15/2018

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

Tamara Lefranc, Esq. from Law Office of Aloy O. Ibuzor participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, \$ **1,375.00**, 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

Whether Applicant is entitled to reimbursement for lumbar spine decompression rendered from December 17, 2015, to January 2, 2016, as a result of an October 12, 2015, motor vehicle accident.

Respondent denied reimbursement based upon a January 15, 2016, peer review of Neal Pignatora III, D.C.

Respondent also asserted the defense that Applicant's fees were in excess of those allowed pursuant to the Fee Schedule.

This Award is based upon a review of all of the documents contained within the ADR Center electronic case file as of the date of the Award, as well as upon any oral arguments of the parties and any testimony given during the hearing.

4. Findings, Conclusions, and Basis Therefor

The 83 year old EIP was reportedly involved in a motor vehicle accident on October 12, 2015, when the vehicle in which she was the restrained front seat passenger rear-ended a vehicle that stopped suddenly.

According to the records, immediately following the accident the EIP was transported by ambulance to Millard Fillmore Suburban Hospital where she presented reportedly complaining in part of mild back pain. Lumbar x-rays were with the impression of advanced osteoporosis, no obvious compression or other fracture, and degenerative spondylosis which may be contributing to spinal stenosis. The EIP was diagnosed with lumbar sprain and released.

On October 15, 2015, the EIP presented for initial chiropractic evaluation with Thomas Skraitz, D.C., reportedly complaining in part of 9/10 lower back pain that could radiate across the iliac crests and difficulty standing quickly from either a recumbent or seated posture. It is noted from the records that Dr. Skraitz and various colleagues had been treating the EIP in part for a lumbar injury sustained in a July 8, 2013, motor vehicle accident just prior to the happening of the October 12, 2015, accident. Examination reportedly revealed difficulty straightening into an erect stance, loss of lumbar lordosis, decreased lumbar range of motion in all planes with pain, positive Kemp's bilaterally for sharp lumbosacral pain, rigid spasticity of the lumbar paraspinal musculature, and segmental dysfunction in the lower lumbar spine. Dr. Skraitz diagnosed the EIP in part with lower back strain, muscle contracture, and myositis.

On December 17, 2015, the EIP presented for treatment with Dr. Skraitz reportedly complaining of frequent 6-7/10 lower lumbar spine pain radiating into the bilateral buttocks. The EIP underwent a session of spinal decompression.

On December 19, 2015, the EIP presented for treatment with Raymond Evans, D.C. The EIP reported more balance and less leg pain. The EIP again underwent a session of spinal decompression.

On December 22, 2015, the EIP presented for treatment with Dr. Skraitz. The EIP reported less intense lumbar pain. The EIP again underwent a session of spinal decompression.

On December 26, 2015, the EIP presented for treatment with Dr. Evans reportedly complaining in part of 5/10 lumbar, bilateral sacroiliac, sacral, and right buttock pain. The EIP reported less pain going down into the leg. The EIP again underwent a session of spinal decompression.

On January 2, 2016, the EIP again presented for treatment with Dr. Evans. The EIP reported a decrease in her lumbar radicular symptoms. The EIP again underwent a session of spinal decompression.

On March 9, 2016, the EIP underwent a chiropractic independent medical examination ("IME") performed by Neal Pignatora III, D.C. At the time of this IME the EIP was reportedly complaining in part of 7/10 low back pain and occasional right leg pain with standing for approximately 12 minutes. Following examination, Dr. Pignatora diagnosed the EIP in part with resolving lumbar sprain/strain and recommended continued chiropractic treatment once per week for four weeks followed by once every other week for eight weeks.

RESPONDENT'S PEER REVIEW

On March 9, 2016, Dr. Pignatora performed a peer review of the lumbar spine decompression. Dr. Pignatora concluded that medical necessity had not been established for the treatment. Dr. Pignatora opined:

The New York Mid and Low Back Medical Treatment Guidelines (12/10) states that D.10.o Vertebral Axial Compression (VAX-D) and Other DE compressive Devices recommendations are that Vax-D or other spinal decompressive devices is not recommended for acute, sub-acute, chronic or radicular pain syndromes. Therefore, based on the review of the provided records, it is my opinion that Vertebral Axial Decompression is not medically necessary and should not be allowed and that all future decompression treatment should be denied according to the New York State Medical Treatment Guidelines (12/10).

Based upon Dr. Pignatora's opinion, Respondent denied Applicant's claim.

ANALYSIS

Once an applicant has established a prima facie case of entitlement to No-Fault benefits, the burden then shifts to the insurer to prove that the disputed services were not medically necessary. To meet this burden, the insurer's denial(s) of the applicant's claim(s) must be based on a peer review, IME report, or other competent medical evidence that sets forth a clear factual basis and a medical rationale for the denial(s).

Amaze Medical Supply, Inc. v. Eagle Ins. Co., 2 Misc. 3d 128A (App. Term, 2nd Dept., 2003); Tahir v. Progressive Cas. Ins. Co., 12 Misc. 3d 657 (N.Y.C. Civ. Ct., N.Y. Co., 2006); Healing Hands Chiropractic, P.C. v. Nationwide Assurance Co., 5 Misc. 3d 975 (N.Y.C. Civ. Ct., N.Y. Co., 2004); Millennium Radiology, P.C. v. New York Cent. Mut., 23 Misc. 3d 1121(A) (N.Y.C. Civ. Ct., Richmond Co., 2009); Beal-Medea Prods., Inc. v GEICO Gen. Ins. Co., 27 Misc. 3d 1218(A) (N.Y.C. Civ. Ct., Kings Co., 2010); All Boro Psychological Servs., P.C. v GEICO Gen. Ins. Co., 34 Misc. 3d 1219(A) (N.Y.C. Civ. Ct., Kings Co., 2012).

I find that Dr. Pignatora's peer review fails to set forth a clear factual basis and a medical rationale for Respondent's denial of Applicant's claim for the lumbar spine decompression in dispute herein and as such I find that Respondent has failed to establish a lack of medical necessity for same.

As an initial matter, I concur with several of my fellow arbitrators that the N.Y.S. Workers' Compensation Board Medical Treatment Guidelines are authoritative in No-Fault cases but not dispositive.

In Elite Medical NY, PC and Allstate Property and Casualty Insurance Company, AAA Case No. 412014018767 (10/27/14) Arbitrator Glen Weiner held:

Faced with apparent differing standards it is logical to look at the only codified treatment guidelines in New York State, *The New York State Worker's Compensation Board Treatment Guidelines*. These Guidelines developed by representatives from the Insurance Department, the Worker's Compensation Board, the Department of Labor, and most importantly "highly qualified and respected medical professionals selected by labor, business, and the Insurance Department" are codified and are contained in the New York Codes, Rules, and Regulations at 12 NYCRR Part 324. With respect to worker's compensation claims, these Treatment Guidelines are the mandatory standards of care for back, neck, shoulder, and knee injuries, effective for dates of service, on or after December 1, 2010. While not dispositive in no-fault cases, these Guidelines are highly persuasive as to what the generally accepted medical practice is for treatment of neck, back and knee injuries in the State Of New York. Both worker's compensation claims and no- fault claims are similar in that they both involve trauma and injuries to individuals who then require treatment.

In Southside Hospital (NSUH) and Geico Insurance Company, AAA Case No. 17-16-1043-7580 (12/3/17) Arbitrator Rhonda Barry, citing to Arbitrator Weiner's Award, held:

I agree that the Guidelines are not necessarily controlling in no-fault cases. However, as Arbitrator Wiener noted, "[I]t is logical to look at the only codified treatment guidelines in New York State, the New York State Worker's Compensation Board Treatment Guidelines. These guidelines developed by representatives of the insurance department, the Worker's Compensation Board, the Department of Labor and most importantly highly qualified and respected medical professionals... are codified and are contained in the New York codes, rules and regulations at 12 NYCRR part 324." (Elite Medical Care New York, PC v. Allstate Property Casualty Insurance Company, AAA # 412014018767, Arbitrator Wiener, 10/27/14). The Guidelines (Workers Compensation and ODG) offer well researched information that can, when coupled with the peer reviewer's expertise, suggest a generally accepted standard of care for the medical community as a whole. The Guidelines are certainly admissible at arbitration and will be given appropriate consideration.

In addition Arbitrator Frank Marotta, in reliance on both Arbitrator Weiner's and Arbitrator Barry's Awards, reached the same conclusion regarding the authoritative but non-dispositive nature of the N.Y.S. Workers' Compensation Board Medical Treatment Guidelines (*see* Longevity Medical Supply, Inc. and Geico Insurance Company, AAA Case No. 17-16-1051-0569, 1/17/10).

In each of the three cases cited above, the respondents' medical experts rendered their opinions as to lack of medical necessity through analyses that considered both the standards of care set forth by the N.Y.S. Workers' Compensation Board Medical Treatment Guidelines as well as other authoritative sources and the information contained within the medical records.

In the case at bar, however, Dr. Pignatora only opined that "based on a review of the provided records" lumbar spine decompression was not medically necessary and should be denied according to the New York Mid and Low Back Medical Treatment Guidelines.

The issue with Dr. Pignatora's opinion is that although he recited the contents of the medical records he reviewed he offered no explanation as to why these records evidenced lack of medical necessity. This failure is significant given that the medical records show that the EIP was in fact greatly benefitting from the disputed lumbar spine decompression. In addition, it is noted that following his March 9, 2016, IME Dr. Pignatora was of the opinion that the EIP should continue chiropractic treatment.

Therefore, based upon the foregoing, Respondent's denial cannot be upheld.

AMOUNT AWARDED

As noted above, Respondent also asserted in its denials the defense that Applicant's fees were in excess of those allowed pursuant to the Fee Schedule.

With respect to the amount to be awarded Applicant herein, on April 1, 2013, the Fourth Amendment to Regulation 68-C became effective which amended 11 NYCRR §65-3.8(g) as follows:

"(1) Proof of the fact and amount of loss sustained pursuant to [Insurance Law section 5106\(a\)](#) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances:

(i) when the claimed medical services were not provided to an injured party; or

(ii) for those claimed medical service fees that exceed the charges permissible pursuant to [Insurance Law sections 5108\(a\)](#) and (b) and the regulations promulgated thereunder for services rendered by medical providers.

(2) This subdivision shall apply to medical services rendered on or after April 1, 2013."

According to Applicant's evidence, there are five dates of service in dispute herein for which Applicant charged the amount of \$275.00 under code S9090.

Code S9090 is a HCPCS Medicare billing code which has not heretofore been adopted by the Chairman of the N.Y.S. Workers' Compensation Board for inclusion within N.Y.S. Workers' Compensation Fee Schedule, and Applicant has not submitted any evidence indicating that it was permitted to bill this code for No-Fault claims.

HCPCS code S9090 has a specific description, which is "vertebral axial decompression, per session".

Page "9" of the November 2004 CPT Assistant states as follows in relevant part:

Vertebral Axial Depression

Vertebral axial depression therapy is an alternative, noninvasive, nonsurgical procedure of applying traction to the spine. It can be used in the treatment of several conditions, including low back pain associated with lumbar disc herniation, degenerative disc disease, posterior facet syndrome, and radiculopathy. The objectives of vertebral axial depression therapy are the relief of disabling low back pain and return to normal functioning in patients with lumbar disc disease.

The vertebral axial depression and therapeutic table is a fully automated, computerized system with a split-table design and a tensionometer mounted on the caudal, moveable section. The patient wears a pelvic harness that is fastened around the pelvic girdle and is connected to a tensionometer by straps attached to the harness. The patient lies in a prone position and grasps handgrips to restrain movement of the upper body, which is supported on the fixed section of the table. The caudal end of the table, which supports the lower body, slowly extends, applying a distraction force via the pelvic harness connected to the tensionometer. The health care professional at the control console determines the level of applied tension. The movement of the table is stopped and held when the desired tension is reached. A cycle of one minute of distraction is alternated with 30 seconds of rest. Opinions differ on the average number of sessions required to reach the desired outcome. With any intervention, the length of the episode of care is partially dependent on the patient's response to treatment.

CPT Code 97012

CPT code 97012, *Application of a modality to one or more areas; traction, mechanical*, is intended to identify a procedure that creates a force to allow for separation between joint surfaces. The degree of traction is controlled through the amount of force (pounds or Newtons) allowed, duration (time), and angle of pull (degree) using mechanical means. Therefore, code 97012 would be the most appropriate code to report for various types of mechanical traction devices (eg, computerized/motorized) including vertebral axial depression.

I take judicial notice of CPT Assistant as an authoritative source as it is a publication of the American Medical Society who developed the CPT codes utilized in No-Fault claims and as such is in the best position to interpret and apply said codes and set billing guidelines for same.

In support of its \$275.00 charge for the disputed lumbar spine decompression Applicant submitted a "DRX9000 RVU Calculation Report" which explains the mechanics of spinal decompression, the skill needed to perform spinal decompression, treatment times, the cost of the DRX9000 spinal decompression unit and Applicant's alleged costs for (1) maintenance and operation of the DRX9000, (2) office expenses, (3) malpractice insurance for two chiropractors, and (4) office staff salary.

Even assuming arguendo that it is proper to analyze a treatment code not adopted for inclusion in the N.Y.S. Workers' Compensation Fee Schedule as a "by report" code, General Ground Rule 3 contained within the Introduction and General Guidelines of the N.Y.S. Workers' Compensation Fee Schedule states as follows in relevant part:

"By report (BR) items: "BR" in the Relative Value column represents services that are too variable in the nature of their performance to permit assignment of relative value units. Fees for such procedures need to be justified "by report." Pertinent information concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary, but sufficient information shall be submitted to permit a sound evaluation. It must be emphasized that reviews are based on records, hence the importance of documentation...For any procedure where the relative value unit is listed in the schedule as "BR," the physician shall establish a relative value unit consistent in relativity with other relative value units shown in the schedule. The insurer shall review all submitted "BR" relative value units to ensure that the relativity consistency is maintained. The general conditions and requirements of the General Ground Rules apply to all "BR" items."

This specific general ground rule is also contained within the Introduction and General Guidelines of the Chiropractic Fee Schedule as Ground Rule 2.

The import of this ground rule is that it puts the burden on the healthcare provider in the first instance to (1) submit documentation setting forth pertinent information concerning the nature, extent, and need for the procedure or service, as well as the time, the skill, and the equipment necessary to provide such service, and (2) establish a relative value unit consistent in relativity with other relative value units shown in the schedule.

As respect's Applicant's first burden, its DRX9000 RVU Calculation Report does not satisfy same as it is a generalized boilerplate report which does not state why the EIP was in need of the disputed lumbar spine decompression.

As respect Applicant's second burden, Applicant failed to establish a relative value unit consistent in relativity with other relative value units shown in the Fee Schedule. Indeed, all that Applicant states in the letter is that the applicable RVU conversion factor for its region is \$4.65.

Therefore, based upon all the foregoing, I find that Applicant improperly billed HCPCS code S9090 and further that Applicant has failed to establish entitlement to the claimed

\$275.00 for each of the five dates of service in dispute. Instead, Applicant is awarded the amount of \$12.60 for each of the five dates of service in dispute which represents the allowable Fee Schedule amount for CPT code 97012 in Applicant's Region of II for a total award amount of \$63.00.

ACCORDINGLY, APPLICANT IS AWARDED THE AMOUNT OF \$63.00 TOGETHER WITH INTEREST, ATTORNEY'S FEE, AND FILING FEE AS SET FORTH BELOW. THE REMAINDER OF 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 applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Status
	Daniel C COx DC	12/17/15 - 01/02/16	\$1,375.00	Awarded: \$63.00
Total			\$1,375.00	Awarded: \$63.00

- B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 05/18/2016, which is a relevant date only to the extent set forth below.)

Pursuant to 11 N.Y.C.R.R. §65-3.9(a), the insurer shall calculate interest at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month.

Pursuant to 11 N.Y.C.R.R. §65-3.9(c), if an applicant does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken.

Since Applicant herein did not request arbitration within 30 days of receipt of the denial of claim form, Respondent shall pay interest from the date the arbitration was commenced as set forth above to the date of payment of the Award in accordance with 11 N.Y.C.R.R. §65-3.9(c).

C. Attorney's Fees

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

The insurer shall pay the Applicant an attorney's fee in accordance with 11 N.Y.C.R.R. §65-4.6(d) as Amended by the Sixth Amendment to Regulation 68 effective February 4, 2015.

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

02/22/2018

(Dated)

Michelle Murphy-Louden

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:
002d9b1a07a7f84f36904f801c141151

Electronically Signed

Your name: Michelle Murphy-Louden
Signed on: 02/22/2018