

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

| | | |
|---|--------------------------|------------------|
| FJ Orthopaedics & Pain Management PLLC (Applicant) | AAA Case No. | 17-17-1077-8548 |
| | Applicant's File No. | None |
| - and - | Insurer's Claim File No. | 0299919960101039 |
| Geico Insurance Company (Respondent) | NAIC No. | 22063 |

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: DS

1. Hearing(s) held on 06/08/2018
Declared closed by the arbitrator on 06/08/2018

Robin Grumet, Esq. from Jakubowitz Law Firm PC participated in person for the Applicant

Alberto de Chavez from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, \$ 1,037.39, was AMENDED and permitted by the arbitrator at the oral hearing.

The claim was amended to \$621.39 to bring reflect the withdrawal, with prejudice, of the claims reported under CPT codes J3301, S0020, J2001, and A4215 and to bring it into compliance with Applicant's view of the fee schedule.

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

The parties stipulated to the timely service of all bills and denials, to Applicant's *prima facie* showing of entitlement to reimbursement and that any interest due shall run from the date of the initiation letter.

3. Summary of Issues in Dispute

The issues to be determined are the medical necessity of upper and lower extremity electrodiagnostic studies for which reimbursement was denied predicated on a peer review and, if medically necessary, whether Applicant's billing was in accordance with the applicable provisions of the New York Workers' Compensation Medical Fee Schedule.

4. Findings, Conclusions, and Basis Therefor

DS, a male who was then 23 years old, was involved in an automobile accident on 9/15/16 while driving. He sustained various injuries and, on 7/7/17, medial branch nerve blocks performed by the Applicant. Reimbursement for the procedure was denied based on the 8/24/17 peer review of physiatrist Jay M. Weiss, MD. Applicant submitted the 10/19/17 direct rebuttal affirmation of treating orthopedist Jonathan Simhaee, MD in response. Dr. Weiss then submitted a 12/20/17 sur-rebuttal.

Medical Necessity

I find the peer review of Dr. Weiss to be facially insufficient to sustain Respondent's *prima facie* burden of establishing a lack of medical necessity for the injections in issue. At the outset, Dr. Weiss identifies the procedure as facet injections. The operative note clearly indicates that the main procedure performed was medical branch nerve blocks. Facet joint injections were not performed. While similar, facet joint injections and medical branch nerve blocks are different in both administration and purpose. The facet joint injection is the injection of an anesthetic agent and a steroid directly into the facet joint for either or both diagnostic purposes and for pain relief. The medical branch nerve block is an injection outside the joint space near the nerve, *i.e.*, the medial branch, that serves the joint. Its purpose is more diagnostic than therapeutic since any pain relief will range from several hours to a few days. Dr. Weiss' review of the procedure as involving facet joint injections makes all of his conclusions irrelevant to the medical necessity of the procedure actually performed. Moreover, the only citation to authority relied on by Dr. Weiss is the New York Workers' Compensation Guidelines, which is neither binding on this forum nor, in my view, of any persuasive value. The Guidelines are not representative of standards of care, although it is certainly possible that they may be based on such standards. Instead, the Guidelines are promulgated by a payor to determine when and under what circumstances the Workers' Compensation Board will pay for various procedures, tests and treatment in conjunction with securing a patient's return to work. Such self interest in the promulgation of Guidelines makes them of little use as a determinant of medical standards outside the specific forum and purpose for which the Guidelines were intended. I therefore find the peer review to be conclusory, irrelevant to the specific procedure involved and that it fails to comport with the standards set forth in *Nir v. Allstate Ins. Co.*, 7 Misc.3d 544, 796 N.Y.S.2d 857 (Civ. Ct. Kings Co. 2005).

Accordingly, the denial is reversed.

Fee Schedule

After the amendment of the claim, that only CPT codes reported that are in issue are 64493(50) (Injection[s], diagnostic or therapeutic agent, paravertebral facet...joint [or nerves innervating that joint] with image guidance....) reported at \$220.45, 64494(50) (second [vertebral] level) reported at \$128.26, 64495(50) (third and any additional levels) reported at \$128.26, and 77003(59) (Fluoroscopic guidance and localization of needle...for spine or paraspinous diagnostic or therapeutic injection procedures...) reported at \$144.42. Modifier 50 represents bilateral procedures and modifier 59 represents a distinct separate procedure.

Respondent submitted a fee audit from a vendor named Techsource that was prepared by an unidentified person, was not signed and did not contain detailed information. Its conclusions 66494 and 66495 were properly billed but that 64493 should be reimbursed in the sum of \$188.96, (allowance made for a bilateral procedure) and that 77003 should not be reimbursed at all since the service is "included in the value of the office visit or other procedure."

The treatment was rendered in Region IV. CPT 66493is assigned a relative value (RV) of 0.55. The Region IV conversion factor is \$229.04. When the conversion factor is multiplied by the RV, the result is \$125.97. Pursuant to Surgery Ground Rule 5, when a bilateral procedure is performed, the second side may only be reimbursed at 50% of the sum permitted for a single procedure. 50% of \$125.97 is \$62.99. Added together, the appropriate reimbursement for the bilateral injections under CPT 64493 is \$188.96 as the fee audit recommended.

CPT 77003, a radiology code, is assigned a RV of 2.73, which, when multiplied by the \$52.90 Region IV conversion factor, equals the \$144.42 reported by the Applicant. I know of nothing in the Ground Rules or in the CPT Analyzer that supports the audit's view that the fluoroscopic guidance is included in the fee for the injections. The audit does not cite any ground rule or interpretive source that would support its conclusion. If the audit's issue was with the use of the modifier, a medical basis would have to be provided to support Respondent's assertion. No such basis was contained in the ECF. Absent some evidence to the contrary, I find that the sum reported for CPT code 77003 was in accordance with the 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 | Amount Amended | Status |
|--------------|---|----------------------------|-------------------|-----------------|--------------------------|
| | FJ Orthopaedics & Pain Management PLLC | 07/07/17 - 07/07/17 | \$1,037.39 | \$621.39 | Awarded: \$589.90 |
| Total | | | \$1,037.39 | | Awarded: \$589.90 |

- B. The insurer shall also compute and pay the applicant interest set forth below. 11/17/2017 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest shall run from the above noted initiation 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.

06/09/2018
(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:
1564f73d9c551fd112e0ef91b59e5e73

Electronically Signed

Your name: Michael B. Parson
Signed on: 06/09/2018