American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Garden State Neuro Stimulation (Applicant)	AAA Case No.	17-16-1052-3946
	Applicant's File No.	781-148 ARB
- and -	Insurer's Claim File No.	52744W852
	NAIC No.	25178
State Farm Mutual Automobile Insurance Company (Respondent)		

ARBITRATION AWARD

I, Anthony Kobets, 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 05/23/2018
   Declared closed by the arbitrator on 05/23/2018

   Michael Nathan, Esq. from Lewin & Baglio LLP participated in person for the Applicant

   Elizabeth Moeller, Esq. from Richard T. Lau & Associates participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,423.18**, was AMENDED and permitted by the arbitrator at the oral hearing.

   At the hearing, Applicant's cousel amended the amount in dispute down to $144.41 total. Specifically, Applicant is only seeking the $144.41 amount billed for CPT code 77003 on date of service 4/29/16. Applicant's counsel withdrew with prejudice the $1278.77 remaining balance for date of service 4/29/16 and 6/3/16, based on the fee schedule. Accordingly, $144.41 is the amended amount in dispute herein.

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

   The parties' representatives stipulated to the Applicant's prima facie burden.

3. Summary of Issues in Dispute

In dispute is the Applicant's claim totaling $1423.18 for lumbar epidural steroid injections with fluoroscopic guidance and an epidurography performed on the patient (MW) on 4/29/16 and 6/3/16 as a result of injuries alleged to have been sustained in a motor vehicle accident on October 13, 2015.

Respondent denied a portion of the claim based upon the New Jersey Fee Schedule. Was the applicant entitled to reimbursement for the services provided to the EIP?

4. Findings, Conclusions, and Basis Therefor

I have reviewed all documents as available in the ADR Center as of the date of this hearing pertaining to this case. This case was decided based on the submissions of the Parties as contained in the electronic case folder maintained by the American Arbitration Association and the oral arguments of the parties at the hearing. There was no witness testimony at the hearing.

At the hearing, Applicant's cousel amended the amount in dispute down to $144.41 total. Specifically, Applicant is only seeking the $144.41 amount billed for CPT code 77003 on date of service 4/29/16. Applicant's counsel withdrew with prejudice the $1278.77 remaining balance for date of service 4/29/16 and 6/3/16, based on the fee schedule. Accordingly, $144.41 is the amended amount in dispute herein.

The parties' representatives stipulated to the Applicant's prima facie burden.

The parties' representatives agreed that the fee schedule was the sole issue in dispute herein.

The parties' representatives further agreed that the AAA arbitration commencement date will be utilized for interest purposes, if applicable.

The EIP (MW) was a 43-year old female who was allegedly involved in a motor vehicle accident on October 13, 2015. On 4/29/16, the patient was administered a lumbar spine epidural steroid injection with fluoroscopic guidance and an epidurography performed by the Applicant. Applicant seeks no-fault reimbursement for the fluoroscopic guidance billed under CPT code 77003.

A health care provider establishes its *prima facie* entitlement to payment as a matter of law by proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law § 5106 a; Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]; Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784 N.Y.S. 2d918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]).

Fee schedule

Applicant herein billed CPT code 62311 for date of service 4/29/16 and was reimbursed 100% of the fee schedule rate in the amount of $879.37. Applicant also billed CPT code 72275 "Epidurography, radiological supervision and interpretation" and was reimbursed 100% of the fee schedule amount of $572.81. Applicant was denied any reimbursement for CPT code 77003 in the fee schedule amount of $144.42 for "Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinuous diagnostic or therapeutic injection procedures (epidural or subarachnoid)." Respondent denied payment of this CPT code indicating: "included in…, Line 2 ServiceCode-72275". Respondent's denial also indicated "The CPT/HCPS code(s) reported by provider are included in another procedure reported on the bill."

At the hearing, Respondent's counsel argued that CPT code 77003 was properly denied because it is included in the more comprehensive CPT code 62311 and CPT code 72275 and should not be reimbursed separately. At the hearing, Applicant's counsel argued that the amounts billed were appropriate per the fee schedule and that payments should have accordingly been issued.

It is well established that a healthcare provider must limit its charges according to the applicable fee schedule. Goldberg v. Corcoran, 153 AD2d 113, 117-18 (App Div, 2d Dept 1989). An insurance carrier's timely asserted defense that the bills submitted were not properly no-fault rated or that the fees charged were in excess of the Workers' Compensation Fee Schedule is sufficient, if proven, to justify a reduction in payment or denial of claim. New York Hosp. Med. Ctr. Of Queens v. Country-Wide Insurance Company, 295 A.D.2d 583, 744 N.Y.S.2d 201 (2nd Dept. 2002); East Coast Acupuncture, P.C. v. New York Central Mutual Insurance, 18 Misc.3d 139(A), 2008 N.Y. Slip Op. 50344(U) (App. Term 2nd and 11th Jud. Dists. 2008); A.B. Medical Services, PLLC v. American Transit Insurance Company, 15 Misc.3d 132(A), 2007 N.Y. Slip Op. 50680(U) (App. Term 2nd and 11th Jud. Dists. 2007).

The insurer has the burden of coming forward with competent evidentiary proof to support its fee schedule reduction or denial. See, e.g., Roberts Physical Therapy, P.C. v. State Farm Mutual Automobile Insurance Company, 13 Misc.3d 172, 3006 N.Y. Slip Op. 26240 (N.Y. Civ. Ct. Kings Co. 2006). In the absence of such proof, a defense of noncompliance with the appropriate fee schedule cannot be sustained. Continental Medical, P.C. v. Travelers Indemnity Company, 11Misc,3d 145(A), 2006 N.Y. Slip Op. 50841(U) (App. Term 1st Dept. 2006). When services are rendered outside of New York but in a jurisdiction which utilizes a No-Fault fee schedule, the insurer complies with 11 NYCRR 65.6 by paying the amount permitted by that jurisdiction's fee schedule. Surgicare Surgical v. National Interstate Ins. Co., 46 Misc.3d 736, 997 N.Y.S.2d 296 (Civ. Ct. Bronx Co. 2014), aff'd, ___ Misc.3d ___, ___ N.Y.S.3d ___, 2015 N.Y. Slip Op. 25338 (App. Term 1st Dept. 2015); Saddle Brook Surgicenter, LLC v. All State Ins. Co., 48 Misc.3d 336, 8 N.Y.S.3d 875 (Civ. Ct. Bronx Co. 2015). I find that the New Jersey Fee Schedule is applicable herein since it is the prevailing fee for the region where the services were rendered.

In support, Respondent herein submitted a sworn letter from Matthew Kenyon, CPC, CPMA, dated 4/12/17, wherein Mr. Kenyon reviewed the CPT codes billed and amounts charged herein and concluded that "CPT code 77003 has been incorrectly reported by the provider. Based on the documentation in the op-report for date of service 04/29/2016, the provider has performed (Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)). CPT code 77003 is an inclusive component as per AMA CPT Guidelines to the primary procedure performed CPT code 62311, therefore, reimbursement is $0.00." Mr. Kenyon also concluded that Respondent overpaid the Applicant $572.81 for that date of service because CPT code 72275 was erroneously reimbursed.

At the hearing, Respondent's counsel argued that the overpayment should be used to offset any amount owed. However, I find that since Respondent specifically issued payment for these specific CPT codes and applied to them on its own accord, none of those funds may be ported over to make up the difference on any of the other CPT Codes at issue. See AAA No. 17-14-1003-8196. Arbitrators are permitted to take judicial notice of the Worker's Compensation fee schedule. Kingsbrook Jewish Medical Center v. Allstate Insurance Company, 61 AD 3d 13 (2d Dept. 2009).

Importantly, the AMA advises physicians that procedures/services should be reported with the HCPCS/CPT codes that most comprehensively describe the services performed. Furthermore, NCCI looks at pairings of CPT codes representing services, which should not be billed together. Incorrect coding, rather than medical necessity, is the concept of NCCI. Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code. NJAC Section 11:3-29.5(d) provides the following: "When multiple procedures are performed in an ASC or in an HOSF in the same operative session, the ASC facility fee or the HOSF fee, as applicable, for the procedure with the highest payment amount is reimbursed at 100 percent and reimbursement of any additional procedures furnished in the same session is 50 percent of the applicable facility fee…"

Based upon the aforementioned, I find that Respondent met its burden and properly denied reimbursement for CPT code 77003. Once the insurer makes a prima facie showing that the amounts charged by a provider were in excess of the fee schedule, the burden shifts to the provider to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. Cornell Medical, P.C. v. Mercury Casualty Co., 24 Misc.3d 58, 884 N.Y.S.2d 558 (App. Term 2d, 11th & 13th Dists. 2009). Applicant herein did not submit sufficient documentation or an explanation to support this code being reimbursed in addition to CPT code 62311. Accordingly, I deny reimbursement for CPT code 77003 in the amount of $144.41. This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of the hearing.

This arbitrator has not made a determination that benefits provided for under Article 51 (the No-Fault statute) of the Insurance Law are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of Assignor. As such and in accordance with the provisions of the prescribed NYS Form NF-AOB (the assignment of benefits), Applicant health provider shall not pursue payment directly from Assignor for services which were the subject of this arbitration, notwithstanding any other agreement to the contrary.

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 claim is DENIED in its entirety

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

06/16/2018
(Dated)

Anthony Kobets

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:
eea8be6e8b4360f13635462fee113228

Electronically Signed

Your name: Anthony Kobets
Signed on: 06/16/2018