American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Bluelight Acupuncture P.C. (Applicant)	AAA Case No.	17-17-1080-4659
	Applicant's File No.	GS-521262
- and -	Insurer's Claim File No.	0236251860101067
	NAIC No.	22063
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Bryan Hiller, 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 06/05/2018
   Declared closed by the arbitrator on 06/05/2018

   Joe Padrucco, Esq. from Law Offices Of Gabriel & Shapiro, LLC. participated in person for the Applicant

   Jesse Brush, Esq. from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 364.65**, 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 Respondent properly reduced/denied payment for the cupping treatment on a fee schedule defense?

   Whether Applicant is entitled to reimbursement for the fees associated with acupuncture and cupping treatment Assignor attended between November 16, 2016 to December 1, 2016 in connection with injuries sustained in a motor vehicle accident on June 12, 2016 in light of the Respondent's Independent Medical Examination performed by Irene Shemelyak, MS, L.Ac. on September 20, 2016?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement, along with interest and counsel fees, under the No-Fault Regulations, for the costs associated with a series of acupuncture and cupping treatments from November 16, 2016 to December 1, 2016 performed in connection with injuries allegedly sustained by Assignor in a motor vehicle accident on June 12, 2016. The cupping treatment was partially paid with the remainder denied on the basis of a fee schedule defense. The acupuncture and cupping treatments at issue after September 27, 2016 were denied following an Independent Medical Examination conducted by Irene Shemelyak, M.S., L.Ac. on September 20, 2016 performed at Respondent's behest after which all acupuncture treatment was effectively cut-off on September 27, 2016. All denials were timely. This decision is based upon the written submissions of counsel for the respective parties as well as oral arguments. A hearing was conducted on June 5, 2018. I have reviewed the documents contained in the Record as of the date of the hearing.

Assignor, a then 42 year old male driver, was involved in a right sided motor vehicle accident on June 12, 2016. Following the accident, Assignor did not seek any immediate or emergent hospital care. As symptomology of injuries related to the accident persisted, Assignor came under the care under the care of multiple conservative care providers for treating including physical therapy, chiropractic care and acupuncture at Applicant Bluelight Acupuncture PC. At his acupuncture initial evaluation on June 14, 2016, two days post-accident, Assignor made complaints of neck pain, left shoulder pain, lower back pain and right elbow pain. On Traditional Chinese medical examination, Assignor had a purple tongue with thick coating and a teeth printed body and the acupuncturist noted post-traumatic Qi and blood flow obstructions in the SJ Hand ShaoYang, GB Foot ShaoYang, SI Hand TaiYang, UB Foot TaiYang and LI Hand YangMing meridians. Following the evaluation, Assignor was started on a course of acupuncture at a rate of three times a week. The acupuncture and cupping treatments from November 16, 2016 to December 1, 2016 at Applicant Bluelight Acupuncture PC's facility are at issue in this matter and the progress notes related to those treatments are attached to the Record.

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, 774N.Y.S. 2d 564 [2004]). I find that Applicant established a prima facie case of entitlement to reimbursement of its claim by timely submitted valid bills for the acupuncture and cupping treatment at issue

Since Respondent's denials were timely, it was within its rights to assert that further treatment was medically unnecessary (see Liberty Queens Medical, P.C. v. Liberty Mutual Insurance Co., 2002 NY Slip Op 40420(U), 2002 WL 31108069 (App. Term 2d & 11th Dists. June 27, 2002)). A treatment or service is medically necessary if it is "appropriate, suitable, proper and conducive to the end sought by the professional health service in consultation with the patient. It means more than merely convenient or useful

treatment or services, but treatment or services that are reasonable in light of the patient's injury, subjective and objective evidence of the patient's complaints of pain, and the goals of evaluating and treating the patient" (see Fifth Avenue Pain Control Center v. Allstate, 196 Misc. 2d 801, 807-808 (Civ. Ct. Queens Cty. 2003)). Medically necessary treatment or services must be "consistent with the patient's condition, circumstances and best interest of the patient with regard to the type of treatment or services rendered, the amount of treatment or services rendered, and the duration of the treatment or services rendered" (Id). Medical services are compensable where they serve a valid medical purpose (see Sunrise Medical Imaging PC v. Lumbermans Mutual, 2001 N.Y. Slip Op. 4009).

If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim (see A.B. Medical Services, PLLC v. Geico Insurance Co., 2 Misc. 3d 26 [App Term, 2nd & 11th Jud Dists 2003]).

With respect to the nineteen sessions of cupping, Applicant billed at a rate of $46.12 per date of treatment. Respondent partially paid in the amount of $43.87 per date of service and denied the remainder based on the fee schedule.

Defendant has the burden to come forward with competent evidence proof to support its fee schedule defenses (see Robert Physical Therapy PC v State Farm Mutual Auto Ins. Co., 2006 NY Slip Op. 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006)).

In support of their position, Respondent relied on the Affidavit of Steven Schram, L.Ac., D.C. dated July 11, 2016. Acupuncturist/Chiropractor Schram argued that that the Assignor incorrectly billed using CPT code 97799 when code 97039 was more appropriate as it code 97799 is not rehabilitative in nature. Nevertheless, he argued that both codes are by report codes where the billing provider should generally submit pertinent information concerning the nature, extent and need for the procedure as well as the time, skill and equipment necessarily involved. He argued that cupping was a simple procedure requiring a minimal amount of technical skill and would require RVU between unattended hot pack and attended ultrasound. Based on these determinations, Chiropractor/Acupuncturist calculated the appropriate billing for the cupping treatment was $43.87 per date of service for a total of $833.53.

In this instance I am persuaded by Chiropractor/Acupuncturist Schram's interpretation of the fee schedule as set forth in his Affidavit and find it sufficiently explained why these particular procedures should be reimbursed as determined by the Respondent. Accordingly, after a careful review of the records and consideration of the parties' oral arguments, I find as a matter of fact that Applicant met its burden of establishing a prima facie case and Respondent to rebut it with sufficient evidence as to its fee schedule interpretation. Applicant's claim for the remainder is denied based on the evidence provided.

With respect to the acupuncture and cupping treatment between November 16, 2016 and December 1, 2016, Respondent timely denied payment of the bills based upon an Independent Medical Exam (IME) by Irene Shemelyak, M.S., L.Ac. conducted on September 20, 2016 with an effective cut-off date of September 27, 2016. Ms. Shemelyak's report noted that at the time of the examination, the Assignor had complaints of pain in the neck, lower back and right shoulder despite improvement of symptoms. After reviewing the available medical records, Ms. Shemelyak performed a physical examination including Chinese traditional medicine. Ms. Shemelyak's cervical spine evaluation revealed no spasm or tenderness, minimal reductions in range of motion on all planes, negative orthopedic testing including Soto Hall, Compression test, Distractoin test and Ashi points tightness and normal neurological examination. Evaluation of the lumbar spine revealed slight range of motion deficits, no spasm, no tenderness, negative Ashi point tightness, negative paresthesia, negative radicular pain and no neurological findings. Examination of the right shoulder revealed no heat, swelling, effusion, erythema, crepitus or impingement, negative Apley's test, normal neurological examination, no Ashi point tightness and slight range of motion reductions on each plane. Traditional Chinese Medical Assessment revealed normal vitality, normal facial skin, an enlarged red purple scalloped tongue with a thin white coating, normal voice, slippery pulse and resolved stagnation of Qi and blood stasis in the UB/DU/SI/SJ/GB and LI channels. Ms. Shemelyak diagnosed Qi and blood stagnation resolved in the UB and DU meridians of the cervical and lumbar spines and Qi and blood stagnation resolved in the SI, LI, SJ and GB meridians of the right shoulder and determined that no further acupuncture treatment was necessary.

An IME report asserting that no further treatment is medically necessary must be supported by a sufficiently detailed factual basis and medical rationale, which includes mention of the applicable generally accepted medical/professional standards (see Carle Place Chiropractic v. New York Central Mut. Fire Ins Co., 19 Misc.3d 1139(A), 866 N.Y.S.2d 90 (Table), 2008 N.Y. Slip Op. 51065(U), 2008 WL 2228633 (Dist. Ct., Nassau Co., May 29, 2008, Andrew M. Engle, J.).

An IME doctor must establish a factual basis and medical rationale for his asserted lack of medical necessity for future health care services (see Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), (App. Term 2d & 11th Dists. Sept. 3, 2008)). Where an IME report provides a factual basis and medical rationale for an opinion that services were not medically necessary, and the claimant fails to present any evidence to refute that showing, the claim should be denied (see AJS Chiropractic, P.C. v. Mercury Ins. Co.,22 Misc.3d 133(A), (App. Term 2d & 11th Dist. Feb. 9, 2002)), as the ultimate burden of proof on the issue of medical necessity lies with the claimant (see Insurance Law § 5102; Wagner v. Baird, 208 A.D.2d 1087 (3d Dept. 1994)).

If the insurer presents sufficient evidence establishing a lack of medical necessity, then the burden shifts back to the Applicant to present its own evidence of medical necessity (see West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc3d 131A (2006)). Once the insurer [Respondent] makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity, "[Applicant] must rebut it or succumb" (see Bedford Park Med. Practice P.C. v American Transit Tr. Ins. Co., 8 Misc. 3d 1025 (A), 2005, 2005 NY Slip Op 51282 citing Bauman v Long Island Railroad,

110AD2d 739, 741, [2d Dept 1985]). As a general rule, reliance on rebuttal documentation will be weighed in light of the documentary proofs and arguments presented at the arbitration. Moreover, the case law is clear that a provider must rebut the conclusions and determinations of the IME doctor with his own facts (see Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co., 37 Misc.3d 19 (App. Term 2d, 11 & 13 Dists. 2012)).

Applicant did not submit a formal rebuttal to the IME examination report but relied upon the progress notes for the treatment at issue. The progress reports were generally illegible and provided no information except noting continued treatment without any examination or test findings.

On the basis of the my review of the medical evidence submitted by the parties and listening to the arguments of counsel, I find that Respondent has met its burden of proving that there was no medical necessity for the acupuncture and cupping treatment between November 16, 2016 and December 1, 2016. Independent Medical Examiner Ms. Shemelyak did a full evaluation including orthopedic testing and traditional Chinese medicine tests and found no acupuncture issues at the time of the examination. Applicant's documentation submitted to rebut the findings of the IME are extremely limited and only show continued treatment rather than any continued issues. Thus, comparing the relevant evidence presented by both parties and the above referenced medical necessity standard, I find in favor of the Respondent and deny the Applicant's claim in full.

Based on the above determinations, Applicant's claim is denied in full in full disposition of this matter.

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

07/29/2018
(Dated)

Bryan Hiller

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:
c6a699547c5663178987cd409c7f7bbf

Electronically Signed

Your name: Bryan Hiller
Signed on: 07/29/2018