American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Western Janeda Orthopedics Of New Jersey (Applicant)	AAA Case No.	17-17-1082-5196
	Applicant's File No.	N/A
	Insurer's Claim File No.	LA000-035357047-02
- and -	NAIC No.	36447
Liberty Mutual Insurance Company (Respondent)		

ARBITRATION AWARD

I, Deepak Sohi, 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 07/11/2019
   Declared closed by the arbitrator on 07/11/2019

   Elvira Messina from Costella & Gordon LLP participated in person for the Applicant

   Charles Schreier from Liberty Mutual Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 30,498.06**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount claimed was amended to $8,966.49 to reflect payment pursuant to and to comport with the New Jersey Automobile Medical Fee Schedule.

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

   The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bill. The parties also stipulated that Respondent's NF-10 denial of claim form was timely issued.

3. Summary of Issues in Dispute

This arbitration arises out of arthroscopic surgery of the right knee and platelet rich plasma injection, provided to the EIP, a 59-year-old male, who was involved in a motor vehicle accident as a driver on 4/3/2017. Applicant is seeking reimbursement for the arthroscopic surgery of the right knee provided to the EIP on date of service 6/16/2017.Respondent denied reimbursement for the arthroscopic surgery of the right knee based on an Independent Medical Peer Review performed by Dr. Jules Hip-Flores, MD, on 7/28/2017.

4. Findings, Conclusions, and Basis Therefor

This case was decided on the submissions of the parties as contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association and the oral arguments of the parties' representatives at the hearing. No witnesses testified at the hearing. I reviewed the documents contained in the ECF for both parties and make my decision in reliance thereon.

FEE SCHEDULE

RIGHT KNEE ARTHROSCOPIC SURGERY & PLATELET RICH PLASMA INJECTION

DATE OF SERVICE 6/16/2017

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). See also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co., 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006).

11 NYCRR 65-3.8(g)(1), in effect as of April 1, 2013, provides that 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 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. As such Respondent is not required to establish that it preserve a fee schedule defense in a timely denial of claim.

To support its denial Respondent has submitted a coding letter from Beth Palisin, a Registered Nurse (RN) with a Bachelor of Science in Nursing (BSN) who is also a Certified Professional Coder (CPC). Ms. Palisin states that the bill presented describes a New Jersey provider submitting charges for primary surgeon's services performing services associated with right knee arthroscopic surgery under a NYS No-Fault claim. Pursuant to Regulation 83, 68.6, if a professional health service is performed outside of NYS, the permissible charge is the prevailing fee in the geographic area of the provider. Since services were rendered in Paterson, New Jersey, reimbursement by Liberty Mutual is warranted in compliance with AMA CPT coding guidelines and the New Jersey Automobile Medical Fee Schedule (NJFS) effective for treatment rendered on or after January 4, 2013.

Judicial notice of the New Jersey Automobile Personal Injury Protection Medical Fee Schedule is taken. See Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, (2nd Dept. 2009); LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), 2011 NY Slip Op 51721(U) (App Term 2d, 11th & 13th Jud Dists. 2011); Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A), 2011 NY Slip Op 50040(U) (App Term, 1st Dept. 2011).

Consequently, she reviewed the bill in accordance with the NJFS. According to Ms. Palisin:

> "Provider billed code 0232T defined as injection(s) platelet rich plasma, any site, including image guidance, harvesting and

preparation when performed. However, per NJAC 11:3-29.4 (g) 5, Platelet Rich Plasma (PRP) injections are only reimbursable for treatment of chronically injured tendons that have failed to improve despite appropriate conservative treatments. (enclosure #2 part B) This criteria has not been met, and therefore code 0232T denied in full.

Additionally, provider billed unlisted CPT code 29999. Per NJAC 11:3-29.4(k) CPT codes for procedures described in CPT as "unlisted procedure" or "unlisted service" (example: 64999 Unlisted procedure nervous system) are not reimbursable without documentation from the provider describing the procedure or service performed, demonstrating its medical appropriateness and indicating why it is not duplicative of a code for a listed procedure or service. Documentation may include the existence of temporary or AMA Category III or HCPCS codes for the procedure or information in the AMA CPT Assistant publication. In submitting bills for unlisted codes, the provider should base the fee on a comparable procedure. (enclosure #2 part C) Service billed under code 29999 is not identified. Provider did not submit required documentation to substantiate reporting code 29999 in accordance with the NJ Fee Schedule. As such, code 29999 denied in full.

Per NJAC 11:3-29.4 (g), providers and payors shall use the National Correct Coding Initiative Edits including the use of modifier 59, as updated quarterly by CMS. (enclosure #2 part D) Per the National Correct Coding Edits, code 29870 is not separately reimbursed from code 29880. (enclosure #3 part A) It is noted that provider appended modifier 59 to code 29870. Per NCCI, modifier 59 may only be used when a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury is extensive injuries) is supported. (enclosure #3 part B). This criteria has not been met by provider documentation. Use of modifier 59 not validated. Further, per AMA CPT coding guidelines, surgical endoscopy/arthroscopy (29880) always includes a diagnostic endoscopy/arthroscopy (29870). (enclosure #4 part A).

Lastly regarding code 29870, code 29870 is designated by AMA CPT coding guidelines as a separate procedure. (enclosure #4 part B) The codes designated as "separate procedure" should not be reported in addition to the code for the total procedure or service of which it is considered an integral component. (enclosure #4 part C). Based on the above, code 29870 denied in full. Codes 29880 & code 29875 are both listed in the NJ fee schedule region North. (enclosure #2 part E).

Finally, provider billed for multiple procedures on the same date. Per NJAC 11:3-29.4 (f) 1, for multiple surgeries, surgical procedures are ranked in descending order by the fee amount, using the fee schedule or UCR amount as appropriate. The highest valued procedure is reimbursed at 100 percent of the eligible charge. Additional procedures are reported with modifier 51 and are reimbursed at 50% of the eligible charge. (enclosure #2 part F).

Summary based on the above:

29880.59-RT: $3,774.79

29875.59-RT: $1,356.08

29870.59-RT: $0.00

29999.59-RT: $0.00

0232T.59-RT: $0.00

Total: $5,130.87

Eligible amount due based on above review: $5,367.81."

By producing the documentation from a Certified Professional Coder, I find that Respondent met its burden to come forward with competent evidentiary proof in support of its Fee Schedule defense.

Once Respondent makes a prima facie showing that the amounts charged by Applicant were in excess of the Fee Schedule, the burden shifts back to

Applicant to show the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error (see Cornell Medical P.C. v. Mercury Casualty Co., 24 Misc.3d 58 (App. Term 2d, 11 & 13 Dists. 2009).

Applicant has not submitted any evidence from a certified professional coder or medical expert or from anyone refuting Ms. Palisin's calculations or demonstrating that Ms. Palisin is incorrect in her analysis. Respondent submitted credible evidence from an RN who is also a Certified Professional Coder establishing the reimbursement amount for these services performed by the primary surgeon and Applicant has not submitted any evidence refuting this calculation or rebutting Ms. Palisin's conclusions.

I find that the Respondent has met its burden with regard to its reduction of the amount claimed and sufficiently established that the amount for the services provided should be $5,367.81 pursuant to the NJFS. Applicant has not come forth with any evidence, whether it be a fee audit, an affidavit from a medical doctor or certified professional coder or any other professional, law or regulation, to demonstrate why it would be entitled to $8,966.49 or $30,498.06 for that matter.

MEDICAL NECESSITY

RIGHT KNEE ARTHROSCOPIC SURGERY & PLATELET RICH PLASMA INJECTION

DATE OF SERVICE 6/16/2017

Applicant has established its prima facie case with 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. 2d 918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud. Dists.]). The burden shifts to the Respondent to prove that the services were not medically necessary.

If an insurer asserts that a medical test, treatment, supply or other service was not medically necessary, 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]; Kings Medical Supply Inc. v. Country Wide Insurance Company, 783 N.Y.S. 2d at 448 & 452; Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc. 3d 128 [App Term, 2nd & 11th Jud. Dists. 2003]).

In support of its denial, the Respondent submitted the Independent Medical Peer Review of Dr. Jules Hip-Flores, MD, dated 7/28/2017. It was Dr. Hip-Flores' determination that the right knee arthroscopic surgery and platelet rich plasma were not medically necessary. To support that determination, Dr. Hip-Flores states:

> "Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure), Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed, Unlisted procedure, arthroscopy, Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure), Plasma rich protien injection, Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed, Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure) and Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified were not supported by the Guidelines. Hence were not medically necessary at that time.
>
> In regards to diagnostic arthroscopy following should be noted:
>
> Link/Source:
>
> http://odg-twc.com/

As per ODG Treatment Integrated Treatment/Disability Duration Guidelines, Knee & Leg (Acute & Chronic), 2017, Diagnostic arthroscopy: "Recommended as indicated below for symptomatic non-arthritic knee conditions following appropriate conservative care.

Criteria for diagnostic arthroscopy:

1. Conservative Care: A minimum of 6 weeks, including medications AND/OR physical therapy AND/OR bracing. PLUS

2. Subjective Clinical Findings: Pain and functional limitations continue despite conservative care. PLUS

3. Imaging Clinical Findings: Inconclusive imaging AND absence of moderate-to-severe arthritic changes."

In this clinical setting, as per acupuncture evaluation report by Chungryu Acupuncture P.C. dated 04/16/2017 the claimant was recommended acupuncture treatment. As per the evaluation report dated 05/03/2017 by Alan Ng, M.D., the claimant was recommended physical therapy. But here there are no documented evidences that the claimant received any form of conservative treatment. Hence, as per the above guideline, diagnostic arthroscopy was not medically necessary at that time.

In regards to the synovectomy, following should be noted:

Link/Source:

http://www.mdguidelines.com/synovectomy

As per Reed Group, MD Guidelines, Synovectomy, Reason for Procedure: 'Removal of the synovium is done to reduce the symptoms of pain and swelling due to recurrent or persistent synovitis. This procedure usually is performed only if the condition is disabling or if the condition has not responded to other, more conservative methods of treatment, such as nonsteroidal anti-inflammatory drugs (NSAIDs), antirheumatic drugs (for RA), or the injection of corticosteroid drugs into the joint itself.'

In this clinical scenario, as per acupuncture evaluation report by Chungryu Acupuncture P.C. dated 04/16/2017 the claimant was recommended acupuncture treatment. As per the evaluation report dated 05/03/2017 by Alan Ng, M.D., the claimant was recommended physical therapy. But here there are no documented evidences that the claimant received any form of conservative treatment. Also there is no documentation which substantiates that the claimant had received corticosteroid drugs into the joint. Hence, arthroscopy with synovectomy was not medically necessary at that time.\

In regards to Arthroscopy of right knee with meniscectomy, following should be noted:

Link/Source:

http://www.odg-twc.com/

As per, ODG Treatment, Integrated Treatment/Disability Duration Guidelines, Knee and Leg (Acute and Chronic), 2017, Meniscectomy "ODG Indications for Surgery- Meniscectomy: "Recommended as indicated below for symptomatic meniscal tears in younger patients, primarily for traumatic tears.

Criteria for meniscectomy or meniscus repair (It is recommended to require 2 symptoms and 2 signs to avoid arthroscopy with lower yield, e.g., pain without other symptoms, posterior joint line tenderness that could signify arthritis, or MRI with degenerative tear, which is often a false positive). Physiologically younger and more active patients with traumatic injuries and mechanical symptoms (locking, blocking, catching, etc.) should undergo arthroscopy without PT.

1. Conservative Care: (Not required for locked/blocked knee.) Exercise/Physical therapy (supervised PT and/or home rehab exercises, if compliance is adequate). AND (Medication. OR Activity modification [e.g., crutches and/or immobilizer].) PLUS

2. Subjective Clinical Findings (at least two): Joint pain. OR Swelling. OR Feeling of giving way. OR Locking, clicking, or popping. PLUS

3. Objective Clinical Findings (at least two): Positive McMurray's sign. OR Joint line tenderness. OR Effusion. OR Limited range of motion. OR Locking, clicking, or popping. OR Crepitus. PLUS

4. Imaging Clinical Findings: (Not required for locked/blocked knee.) Meniscal tear on MRI (order MRI only when above criteria are met)."

In this clinical setting, there is no documented evidence that the claimant had any catching or locking in the knee joint. Also as per acupuncture evaluation report by Chungryu Acupuncture P.C. dated 04/16/2017 the claimant was recommended acupuncture treatment. As per the evaluation report dated 05/03/2017 by Alan Ng, M.D., the claimant was recommended physical therapy. But here there are no documented evidences that the claimant received adequate conservative treatment before proceeding with the meniscectomy surgery. Hence as per the above guideline, right knee meniscectomy was not medically necessary at that time.

In regards to pre-operative, intra-operative, post-operative and extra supplies following should be noted:

Link/Source:

https://www.dir.ca.gov/t8/9789_16_1.html

As per the Chapter 4.5. Division of Workers' Compensation SUBCHAPTER 1. ADMINISTRATIVE DIRECTOR -ADMINISTRATIVE RULES Article 5.3. Official Medical Fee Schedule (a) Global Surgical Package: "pre-operative visits beginning with the day before a major surgery and the day of surgery for minor procedures. Intraoperative services that are normally a usual and necessary part of a surgical procedure. Post-operative visits follow up visits after the surgery that are related to the recovery from the surgery that occurs within the designated

> In this clinical setting, the claimant met with a MVA on 04/03/2017 and right knee arthroscopy was performed on 06/16/2017, since this surgical procedure was not medically necessary at that time; associated service of Plasma rich protein injection and anesthesia was also not medically necessary at that time."

However, according to the MRI of the right knee there were tears of the anterior horn of the lateral meniscus and posterior horn of the medial meniscus and a partial thickness intrasubstance tear of the ACL. The peer review does not adequately discuss these tears and its implications, rather it focuses on a lack of evidence of conservative treatment. Dr. Hip-Flores then discusses the surgery generally and each separate component of the surgery and when they are indicated generally without relating back to the EIP herein. I find the peer review findings to be general, conclusory, unpersuasive and insufficient to meet the Respondent's burden of proof to sustain its defense of lack of medical necessity.

The Applicant has met its initial burden to establish its entitlement to no fault benefits. The burden then shifts to the Respondent. The Respondent's denial for lack of medical necessity must be supported by a peer review or other competent medical evidence which sets forth a clear factual basis and medical rationale for denying the claim. Healing Hands Chiropractic, P.C. v. National Assurance Co., 5 Misc. 3d 975; Citywide Social Work, et. al v. Travelers Indemnity Co., 3 Misc. 3d 608. The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 2009 NY Slip Op 00351 (App Div. 2d Dept., Jan. 20, 2009); Channel Chiropractic, P.C. v. Country-Wide Ins. Co., 2007 Slip Op 01973, 38 A.D.3d 294 (1st Dept. 2007); Bronx Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co., 2007 NY Slip Op 27427, 17 Misc.3d 97 (App Term 1 Dept., 2007), such as by a qualified expert performing an independent medical examination, conducting a peer review of the injured person's treatment, or reconstructing the accident. Id. To successfully support its denial, the Respondent's peer review must address all of the pertinent objective findings contained in the Applicant's medical submissions. The peer review must set forth how and why the disputed services were inconsistent with generally accepted medical and/or professional practices. The conclusory opinions of the peer reviewer, standing alone and without support of medical authorities, will not be considered sufficient to establish the absence of medical necessity. See Citywide Social Work, et. al. v.

Travelers Indemnity Co., supra; Amaze Medical Supply, Inc. v. Eagle Insurance Co., supra. Here, the Respondent has failed to meet its burden of proof to sustain its defense of lack of medical necessity.

The civil courts have held that a defendant's peer review or medical evidence must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review report's medical rationale will be insufficient to meet Respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory, or vague. See generally, Nir v. Allstate, 7 Misc. 3d 544 (Civ. Ct., Kings County 2005). "Generally accepted practice is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." Nir, citing CityWide Social Work & Psychological Servs. v. Travelers Indem. Co., 3 Misc. 3d 608, 612 (Civ. Ct., Kings County 2004).

I find that the peer review of Dr. Jules Hip-Flores, MD, has failed to set forth a sufficient factual basis and medical rationale for his opinion that the disputed services were not medically necessary and therefore has not established, prima facie, a lack of medical necessity for those services rendered by Applicant. The burden has not shifted to the Applicant and has nevertheless been rebutted. This Arbitrator has considered all of the evidence and finds that the Applicant has demonstrated by a preponderance of the credible evidence that the services were medically necessary. The rebuttal addressed the peer review doctor's concerns with specificity and set forth a clear medical basis for the services rendered. The burden never shifted but Respondent's peer review was nevertheless rebutted.

Accordingly, in light of the foregoing, based on the arguments of counsel, and after thorough review and consideration of all submissions, I find in favor of the Applicant for the right knee arthroscopic surgery and platelet rich plasma injection provided for on date of service 6/16/2017, in the amount of $5,367.81.

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.

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**
	Western Janeda Orthopedics Of New Jersey	**06/03/17 - 06/16/17**	**$30,498.06**	**$8,966.49**	**Awarded: $5,367.81**
Total			**$30,498.06**		**Awarded: $5,367.81**

B. The insurer shall also compute and pay the applicant interest set forth below. 12/21/2017 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from the filing date for this case until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty-day month.

C. Attorney's Fees

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

After calculating the sum total of the first-party benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, as provided for in 11 NYCRR 65-4.6(d), subject to a maximum fee of $1,360.00.

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 Nassau

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

07/13/2019
(Dated)

Deepak Sohi

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:
0f30463511f693bbd01bb95b31ca98f3

Electronically Signed

Your name: Deepak Sohi
Signed on: 07/13/2019