

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Hudson Terrace Medical PA
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-18-1107-3726
Applicant's File No.	NF 28320
Insurer's Claim File No.	0423405000101055
NAIC No.	35882

ARBITRATION AWARD

I, Gerry Wendrovsky, 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 09/04/2019, 11/27/2019
Declared closed by the arbitrator on 11/27/2019

Michael Manfredi from Law Office of Thomas Tona P.C participated in person for the Applicant

Crystal Russo from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 16,704.50**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant amended its claim to \$2,872.32, asserting same was in accordance with the relevant fee schedule.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The EIP, HKR, a 56 year old female, was involved in a motor vehicle accident on 12/15/17. At issue is \$16,704.50, the facility fees for injections performed 4/3/18 - 4/26/18. Respondent timely denied the claim, based upon the peer reviews of Dr. Mitchell Ehrlich, dated 5/24/18 and 5/26/18. The question presented is whether the services were medically necessary.

4. Findings, Conclusions, and Basis Therefor

This case has been decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses. I have reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon, which is in full disposition of the issues before me.

At the hearing of 9/4/19, the matter was continued for the parties to submit a brief addressing their respective fee schedule arguments; interest was not stayed.

At the continued hearing, applicant amended its claim to \$2,872.32, asserting same was in accordance with the relevant fee schedule.

An applicant establishes its prima facie entitlement to judgment as a matter of law by proof that it submitted a claim, setting forth the fact and the amount of the loss sustained, and that payment of no-fault benefits was overdue. *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 A.D. 3d 742 (2nd Dept., 2004). Applicant has submitted sufficient credible evidence to establish its prima facie case.

Peer Reviews

A defense that injections are not medically necessary may properly be established with a peer review [Jacob Nir, as assignee of John Doe and Allstate, 7 Misc. 3d 544, 547 (Civ. Ct. 2005)], which must "set forth a factual basis and medical rationale for the peer reviewer's determination" *Provvedere, Inc. v. Republic Western Ins. Co.*, 2014 NY Slip Op 50219(U) (App. Term 2014). A peer review's medical rationale will be insufficient to meet respondent's burden of proof if: 1) 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 for its findings; or 3) it fails to provide specifics as to the claim at issue, is conclusory or vague. *All Boro Psychological Servs. P.C. v. GEICO*, 2012 NY Slip Op 50137(U) (Civ. Ct. 2012); Nir, *supra*.

For brevity and readability, references to the medical literature are stated as [Cite].

Contending the epidural steroid injections (CESI/LESI) were not medically necessary, respondent relied upon the peer reviews of Dr. Ehrlich, a physiatrist, who reported reviewing the EIP's multiple medical records, and collectively stated, in pertinent part:

".... (the EIP) came under the treatment of Dr. Mah, chiropractor. Injuries were noted to the neck, back, right shoulder, and right knee. She received conservative management treatments. She came under the treatment of Dr. Cho on 2/26/2018. She was complaining of headaches, neck pain radiating to the arms with numbness, back pain radiating to the legs with numbness, and pain in the right shoulder and right knee. Examination reported tenderness and decreased range of motion in the

*neck, back, right shoulder, and right knee. **Strength, sensation, and reflexes were normal with the examination of paresthesias in the hands** . She continued to receive conservative management treatments.... She was seen in follow-up by Dr. Cho on 03/14/2018. Complaints and examination findings were as above.... She underwent **cervical epidural steroid injection with Dr. Cho on 04/03/2018**. She continued to receive conservative management treatments. Electrodiagnostic testing was obtained"*

Dr. Ehrlich then opined the injections were not medically necessary:

*".... **the standard of care for medical necessity of the cervical epidural steroid injection** with epidurography, fluoroscopy, facility fee, and anesthesia services has not been met. This is because the physical examination did not reveal radiculopathy. **There were no neurologic deficits in the upper extremities**. The examination findings centered around the injured joints in the right arm but **lacked the specificity of the segmental neurologic deficits that define radiculopathy**. Imaging study of the cervical spine did not reveal correlative lateralizing disc pathology. Without both those key indicators, there was no medically related reason for an epidural injection.... [WCB Cite].... **Cervical ESIs are not effective for cervical axial pain or non-radicular pain syndromes** and they are not recommended for these indications. They are not recommended as treatment for any non-acute axial neck pain without a radicular component...."*

***the standard of care for medical necessity of the lumbar epidural steroid injection** with epidurography, fluoroscopy, facility fee, and anesthesia services has not been met. This is because **physical examinations did not reveal significant radiculopathy in the lower extremities**. The imaging study of the lumbar spine did not reveal correlative lateralizing disc pathology. Without both those key indicators, there was no medically related reason for an epidural injection.... [WCB Cite] [Cite]...."*

Discussion

At the hearing, respondent argued that as there was no clinical finding of a radiculopathy or neurological deficits, there was no need for either a CESI or LESI; applicant argued the complaints of radiating pain and paresthesia (bilateral hands) warranted the injections.

I have reviewed Dr. Cho's reports dated 2/26/18 and 3/4/18.

CESI

At the outset, I observe the medical treatment guidelines implemented by the WCB have not been adopted by NYS DFS for usage herein. Pursuant to DFS opinion issued 3/7/3 [Ops. Ins. Dept. 03-03-26], a deviation from the WCB treatment guidelines (which was

the sole authority cited in the peer review addressing the CESI) does not establish a deviation from generally accepted medical practice.

Upon a review of the credible evidence, with respect to the CESI, I find respondent has not satisfied its burden, or presented a sufficient defense of lack of medical necessity, so as to shift the burden back to applicant. The peer review is insufficient, unsupported by evidence of a deviation from "generally accepted medical" standards, and fail to cite to medical authority, standard, or generally accepted medical practice for their findings. All Boro, supra; Nir, supra.

I note the records provided a diagnosis of cervical radiculopathy. The documentation demonstrated the injection was within generally accepted medical standards, and detailed the EIP's clinical presentment and need for the CESI, which was "*reasonable in light of the [EIP's] injury, subjective and objective evidence of the patient's complaints of pain, and the goals of evaluating and treating the patient.*" Fifth Avenue Pain Control Center v. Allstate, 196 Misc. 2d 801, 807-808 (Civ. Ct. 2003).

LESI

With respect to the LESI, I find respondent presented a sufficient defense of lack of medical necessity. The burden then shifts back to applicant to present its own evidence of medical necessity [West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc. 3d 131A (App. Term 2006)], by meaningfully referring to, or rebutting respondent's evidence. Yklik, Inc. v. Geico Ins. Co., 28 Misc. 3d 133A (App. Term 2010).

Upon careful review, I find applicant did not submit sufficient evidence that meaningfully referred to or discussed the determination of respondent's expert. See, Pan Chiropractic P.C. v. Mercury Ins. Co., 24 Misc. 3d 136A (App Term 2009). Ultimately, it is applicant who must prove, by a preponderance of the evidence, the services were medically necessary. Dayan v. Allstate Ins. Co., 49 Misc.3d 151 (A) (App. Term 2015).

Fee Schedule

Applicant billed for the CESI (DOS 4/3/18), performed in New Jersey, under cpt **62321/72275** in the amended sum of \$1,436.16, asserting said figure was pursuant to NY EAPG.

I have taken judicial notice of the New Jersey fee schedule. Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 20 (2nd Dept.,2009).

Respondent had the burden of coming forward with competent evidentiary proof supporting its fee schedule defenses. St. Vincent Medical Care PC v. Countrywide Insurance Company, 26 Misc. 3d 146 (A)(App. Term 2010). In the absence of such proof, respondent's fee schedule defense cannot be sustained. Continental Medical, P.C. v. Travelers Indem. Co., 11 Misc. 3d. 145(A), 2006 NY Slip Op 50841(U) (App Term 2006).

Respondent's Position

Respondent argued CPT 62321 was not listed in the New Jersey fee schedule and there was no listing in the ASC fee section for CPT 72275.

Respondent uploaded an unsigned Techsource fee audit dated 11/3/18, asserting that applicant was not entitled to be reimbursed, specifically:

".... REPRICING OF THIS BILL IS NOT POSSIBLE BECAUSE THE RATE CODE IS EITHER NOT BILLED OR THE BILLED RATE CODE IS NOT CORRECT IN ACCORDANCE WITH PART 329 OF TITLE 12 NYCRR, SUBPART 329-2 AMBULATORY SURGERY SERVICES FEE SCHEDULE, AMBULATORY PAYMENT GROUPS (APG) METHODOLOGY. 4730 -A FACILITY-SPECIFIC VALUE IS NOT AVAILABLE FOR THE HOSPITAL OR THE AMBULATORY SURGERY CENTER"

As the hearing, respondent argued the billed codes were not reimbursable, referring to the 33rd Amendment to Regulation 83; **that a code lacking a fee amount was not reimbursable if performed in an ambulatory facility** [NJCA 11:3-29.5(a)], and therefore cpt 72275 was not reimbursable; and that **as cpt 62321 did not appear anywhere in the fee schedule, an ambulatory facility could not be reimbursed for such an unlisted code**, citing New Jersey Manufacturers Insurance Company v. Specialty Center of North Brunswick, 203 A.3d 672 (N.J. App. Div. 2019).

I observe that in New Jersey Manufacturers, the court addressed two previously arbitrated matters, concerning a different cpt (63030), which the fee schedule did not list "as a code eligible for reimbursement for physicians or ASCs". The Court noted, in pertinent part:

*".... The 2012 Fee Schedule listed various CPT codes.... **For some other listed CPT codes, there was no reimbursement figure for an ASC. Clearly, if the CPT code is listed and no amount is set forth for an ASC, the ASC cannot receive payment for that service. (Applicants) argue this case presents the situation where the CPT code in question does not appear at all in the Fee Schedule....** The history of the adoption of the 2012 Fee Schedule supports (the carrier's position We conclude that ASCs should not receive reimbursement for (63030) procedures because no reimbursement was listed in the ASC columns in the Fee Schedule, as originally proposed. This omission provides a clear indication of the Department's intent not to reimburse ASCs for CPT code 63030 procedures...."* (emphasis added)

Applicant's Position

Applicant argued that as the holding in New Jersey Manufacturers concerned a different code, it was inapposite; and referred to a master arbitration award (AAA# 99-18-1103-7037), which concerned the reimbursement under **cpt 62321** for a NJ ambulatory surgery facility (ASC). Therein, I observe the lower arbitrator sustained the same fee schedule defense as articulated herein.

On appeal, Master Arbitrator Trestman, in reversing the award, noted in pertinent part:

*".... Applicant argues Effective 1/1/17, the AMA updated multiple CPT codes; **the CPT code billed by applicant herein, code 62321, is simply the updated version of CPT code 62310 which has always been listed for the surgical service at issue in the NJ PIP fee schedule as reimbursable to an ASC.** Per NJAC 11:3-29.4[e], the NJ PIP fee schedule requires providers to submit their billing utilizing the most recent AMA CPT codes.... **Applicant billed for cervical epidural injections under CPT code 62321 which apparently was the AMA replacement code for CPT code 62310 as of 1/1/17; CPT code 62310 is, in fact, included in the NJ Fee schedule and lists the corresponding fees reimbursable to the physicians and the ASC's.** Notably, the NJ fee schedule has not been amended since the AMA designated code change. **Per NJAC 11:3-29.4[e], when a CPT code for the service performed has been changed since the latest published fee schedule, the provider is required to bill the actual and correct code found in the most recent version of the AMA's coding.** The NJ appellate court case is not on point as it involved a CPT code 63030 which was eliminated from the NJ fee schedule for both doctors and ASC's and code 63030 never provided for ASC reimbursement. In the instant case, CPT code 62310 included ASC reimbursement and was not eliminated from the NJ fee schedule; the code was replaced with code 62321 by the AMA. Based on the foregoing, I am remanding this case back to the lower arbitrator...."* (emphasis added)

On remand (AAA# 17-18-1103-7037), Arbitrator Malone issued a recent award, dated 12/2/19, which in pertinent part noted, in finding for applicant:

*".... The applicant billed a total of \$1,688.08 for the procedures at issue. Cervical injection was billed at **\$829.00 under CPT code 62321 billed at \$572.52 under CPT code 72275** However, **CPT code 62321 is not listed in the New Jersey fee schedule and there is no listing in the ASC fee section for CPT codes 72275 or 77003.** [N.J.A.C. 11:3-29.4(e)]: Codes in the Fee Schedule that do not have an amount in the ASC facility fee column are not reimbursable if performed in an ASC and are not subject to the provision in (e) above concerning services not set forth in or covered by the fee schedules.... (discusses New Jersey Manufacturers and Master Award) I am bound by the Master Arbitrator's determination The applicant billed **\$829.30 for 1 unit CPT code 62321; \$592.52 for 1 unit under CPT code 72275** 59 since this claim is for services rendered after January 23, 2018 New York Regulation 11 NYCRR 68.6 should be considered in determining the appropriate reimbursement amount for the services at issue **reimbursement must be the lesser of either the New Jersey fee schedule or the New York Workers' Compensation Medical Fee Schedule.** The New York Workers' Compensation Medical Fee Schedule provides for reimbursement of **\$396.24 for CPT code 62310 (CPT code 62321 is not listed in the New York fee schedule)**" (emphasis added)*

Applicant herein further argued the absence of an affidavit by a certified professional coder required the fee schedule defense not be sustained.

Conclusion

I note the Master Award did not discuss the reimbursement of cpt 72275; as the New Jersey Fee Schedule does not provide for reimbursement under this code to an ambulatory surgery center (ASC), I sustain the denial of reimbursement for this code. NJCA 11:3-29.5(a).

I am cognizant of 11 NYCRR 68.6, as amended (eff. 1/23/18).

In addressing cpt 62321, upon considerable review, including of awards of colleagues and other Master Arbitrators that addressed the impact of the ruling in New Jersey Manufacturers, supra, I find the reasoning of the Master Arbitrator (AAA# 99-18-1103-7037 as followed on remand), to be persuasive. I deem the 'crosswalking' of codes to be appropriate, and the billing under cpt 62321 to be *de minimus*.

As the subject procedure occurred in the New Jersey North region, cpt 62310 would be billed by an ASC at \$1,012.32.

Applicant is awarded the sum of \$1,012.32.

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
	Hudson Terrace Medical PA	04/03/18 - 04/26/18	\$16,704.50	\$2,872.32	Awarded: \$1,012.32
Total			\$16,704.50		Awarded: \$1,012.32

- B. The insurer shall also compute and pay the applicant interest set forth below. 10/04/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Simple interest on the above awarded amount shall be computed and paid at a rate of 2% per month, commencing on the date the claim was filed in arbitration and ending with 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 the applicant an attorney's fee, in accordance with 11 NYCRR 65-4.6(e).

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

12/25/2019
(Dated)

Gerry Wendrovsky

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:
66058afb466945bbd50cf344e8e26411

Electronically Signed

Your name: Gerry Wendrovsky
Signed on: 12/25/2019