American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

| | | |
|---|---|---|
| Accelerated Surgical Center of North Jersey (Applicant) | AAA Case No. | 17-19-1129-6216 |
| | Applicant's File No. | 230982 |
| - and - | Insurer's Claim File No. | 0472878990101014 |
| | NAIC No. | 35882 |
| Geico Insurance Company (Respondent) | | |

**ARBITRATION AWARD**

I, Kent Benziger, 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: M.O.

1. Hearing(s) held on 05/29/2020
   Declared closed by the arbitrator on 05/29/2020

   Kurt Lundgren from Thwaites, Lundgren & D'Arcy Esqs participated by telephone for the Applicant

   Ann Troxler from Geico Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 5,172.64**, 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

   On October 29, 2017, the Assignor/Eligible Injured Party, a 45-year-old male, was, by history, involved in a motor vehicle accident. At issue is the facility fee for the Applicant, a New Jersey ambulatory surgical center, for bilateral cervical C3/4, C4/5 and C5/6 radiofrequency ablation and a right shoulder joint steroid injection with fluoroscopic localization and guidance. The Applicant billed for CPT 64633. The Respondent denied reimbursement in that the codes were not listed in New Jersey Fee Schedule The issues include whether an Applicant can "crosswalk" or bill for a comparable service under the New Jersey Fee Schedule or other healthcare code, and, whether the 33rd Amendment to the 11 NYCRR Part 68 [Regulation 83] code requires that fee for a New York resident receiving treatment in New Jersey is the lesser of the

prevailing fee in New Jersey or the New York fee in as calculated in the highest applicable region of the state using 3M software program to determine the proper EAPG amount.

This hearing was conducted using the electronic case folder maintained by the American Arbitration Association. All documents contained in that folder are made part of the records of this hearing. I have reviewed the documents contained in the electronic case folder as of the date of this award as well as any documents submitted upon continuance of the case. Any documents submitted after the hearing that have not been entered in the electronic case folder as of the date of this award will be listed immediately below and forwarded to the American Arbitration Association at the time this award is issued for inclusion in said case folder.

4. Findings, Conclusions, and Basis Therefor

On October 29, 2017, the Assignor/Eligible Injured Party, a 45-year-old male, was, by history, involved in a motor vehicle accident. On October 10, 2017, the Assignor was evaluated at Coop City Chiropractic for complaints of cervical and lumbar radiating pain. Upon examination, the Assignor had decreased range of motion in the cervical and lumbar spine. Numerous orthopedic tests were positive including Straight Leg Raising on the right. The assessment including internal derangement of the hip, shoulder, with right rotator cuff tear and impingement syndrome, subluxation, cervical and lumbar herniate discs and radiculopathy. The Assignor commenced conservative care.

Through an examination by Dr Ellen Sue Ginsberg, D.O. on May 22, 2018, the Assignor complained of headaches, neck and low back pain and shoulder pain. On examination, range of motion was decreased in the cervical and lumbar spine. Hypesthesia was noted at C5-C7, Tl on the left side as well as L4-5 on the left side. Numerous orthopedic tests were positive including Leseque's ,sciatic notch , straight leg raising, cervical foramina as well as positive Anterior Drawer, Drawer, and Lachman The assessment was of sprains of the cervical, lumbar and thoracic spine, radiculopathy cervicobrachial syndrome fibromyalgia and cervicocranial syndrome. The treatment plan included trigger points, injections and to continue physical therapy and chiropractic.

On November 5, 2018, the Assignor was evaluated at Bailey Outpatient Medical Services for neck and low back pain On examination, the Assignor had restricted ranges of motion in the cervical and lumbar spine with muscle spasm and tenderness. Positive Spurling, Facet loading and Kemp's tests were noted. Motor strength was 4+/5 in various muscle groups in the upper and lower extremity. The left shoulder revealed restricted range of motion and positive orthopedic signs. The diagnoses included cervicalgia, cervical facet joint inflammation, cervicobrachial syndrome, lumbago, and

shoulder pain. The treatment plans included scheduling bilateral radiofrequency ablation and continued physical therapy.

On December 1, 2018, Dr. Irfan Alladin performed bilateral cervical C3/4, C4/5 and C5/6 radiofrequency ablation under fluoroscopic guidance, a right shoulder joint steroid injection and fluoroscopic localization of needle placement.

The Applicant, Accelerated Surgical Center, billed $5,172.64 for the New Jersey ambulatory surgical facility. The Respondent issued a timely denial for the claim based on an independent medical examination (hereinafter referred to as an IME) by Dr. Montero which terminated orthopedic and related benefits on April 15, 2018.

IME. On April 3, 2018, the Assignor/Eligible Injured Party was examined at the Respondent's request by Dr. Carlos Montero. At the time of the evaluation, the Assignor's complained of neck pain occasionally radiating to the arms, mid and low back pain as well as knee pain and headaches. On examination, there was full range of motion in the cervical, thoracic and lumbar spin. No spasm or tenderness were noted and the neurological exam was normal as to reflexes, muscle strength and sensation. The exam of both knees was also normal with full range of motion with no negative orthopedic findings The impression was of cervical, thoracic and lumbar sprain/strains-resolved and a left knee sprain/strain - resolved.

On August 1, 2018, the Assignor was examined by Dr. Isaiah Florence who was certified in anesthesia with added qualifications in pain management. On examination, range of motion was full in the cervical and lumbar spine. Mild paraspinal muscle spasm was noted in the cervical region. Motor strength and sensation were normal with deep tendon reflexes 3/4 in the biceps, triceps, knees and ankles. The diagnoses were of lumbar and cervical facet joint syndrome and radiculopathy - resolved and muscle spasm - resolving. Dr. Florence found the Assignor's was mildly disabled and that he should continue with physical therapy for eight weeks and then be re-evaluated in eight weeks.

On October 4, 2018, Dr. Florence performed a further evaluation. At the time, the Assignor complained of non-radiating neck and lower back pain. The Assignor noted that he received trigger point injections every other week as well as physical therapy and chiropractic. The Assignor stated that one cervical epidural injection helped him move his head. Following this exam, Dr. Florence found the Assignor's cervical and lumbar facet joint syndrome, radiculopathy and muscle spasm had all resolved.

Analysis. A presumption of medical necessity attaches to a Respondent's admission of the Applicant's timely submission of proper claim forms. The Respondent then bears the burden to prove that the treatment was not medically necessary Kings Med. Supply Inc,

v. Country-Wide Ins., 5 Misc.3d 767 (2004); Behavioral Diagnostics v. Allstate Ins. Co., 3 Misc.3d 246 (2004); A.B. Med. Servs v. Geico Ins. 2 Misc.3d 16 (App. Term 2d Dept. 2003). In this case, the peer review must submit "objective testimony or evidence to establish that his opinion is what is generally accepted in the medical profession." Williamsbridge Radiology v. Travelers, 14 Misc.3d 1231(a) (Civ. Ct Kings Co. 2007). When a carrier uses a peer review as basis for the denial, the report must contain evidence of the applicable generally accepted medical/professional standards as well as the provider's departure from those standards. Acupuncture Prima Care v. State Farm Mut. Auto Ins. Co. 17 Misc. 3d 1135 (Civ. Ct. Nassau, 12/03/07). Therefore, a peer reviewer must thoroughly review the relevant medical records and give evidence of generally accepted medical standards. Then, through careful analysis, the peer reviewer must apply those standards to the facts to document that the treatment in question was not medically necessary. See: CityWide Social Work & Psychological Services v. Travelers Idem. Co., 3 Misc.3d 608, 609 (Civil Ct. Kings Co. 2004).

As a finding of fact, Dr. Montero's IME is not persuasive. The Assignor has a re-evaluation with Dr. Ellen Sue Ginsberg, D.O. in May of 2018 following Dr Montero's April IME. Dr. Ginsberg found reduced range of motion hypesthesia in the upper and lower extremities with numerous positive orthopedic tests finding straight leg raising. Further, the Assignor had positive findings on EMG/NCV studies including bilateral C6 nerve root irritation and right L4 nerve root irritation, both consistent with radiculopathy. MRI studies of the cervical and lumbar spine revealed numerous herniated disc as well as a herniated disc with compression on descending nerve roots.. In sum, the report and clinical findings of Dr. Ginsberg which confirmed the findings on the diagnostic studies are more persuasive than Dr. Montero's report. Further, Dr. Montero failed to adequately discuss the numerous positive findings on the MRI and EMG/NCV studies. The reports from an independent medical examination must contain not only the results of a physical examination, but also incorporate, discuss and review the patient's medical history including all positive clinical and diagnostic findings. Carle Place Chiropractic v. New York Central Mut. Fire Ins. Co., 19 Misc.3d 1139(A), (Dist. Ct. Nassau Co., Andrew M. Engle, J., May 29, 2008).

This treatment was denied on Dr. Montero's IME in March. Yet, an examination in August 2018 by Dr. Florence, at the Respondent's request, noted positive findings including muscle spasm with a findings that the Assignor was mildly disabled. These subsequent findings by a physician examining at the Respondent's request contradict Dr. Montero's IME. In view of all of the evidence, the Respondent has failed to sustain its burden of proof of lack of medical necessity. Nir v. Allstate Insurance Company, 7 Misc.3d 544, 546, 547 (2005):

Fee Schedule. Pursuant to the Fourth Amendment effective April 1, 2013 to 11 NYCRR 65-3.8(g)(1), the Applicant's fees cannot exceed the charges permitted pursuant to the Insurance Law 5108 which would incorporate the Workers Compensation Fee Schedule. If there is a dispute that requires an application or interpretation of the fee schedule, the Respondent has the burden to come forward with competent evidentiary proof to support

its defenses. Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co, 13 Misc.3d 172 (Civil Ct, Kings Co. 2006).

The Applicant originally billed a total of $5,172.64 for CPT 64633 50 destruction by Neurolytic agent, paravertebral fact nerve ($3,036.96) and two units of 64634 50 for each additional facet nerve($1,067.84 x 2). The codes are in the New York State Workers' Compensation Fee Schedule, but are not listed in the New Jersey Fee Schedule which is where the services were performed. Applicant contends that New Jersey Fee Schedule allows for reimbursement of services provided by Ambulatory Surgery Centers (ASC) at a rate to similar codes in the New Jersey Fee Schedule. The Respondent has a two tier defense. Respondent first relies on New Jersey Manufacturers Insurance Company v. Specialty Center of North Brunswick, 203 A.3d 672 (N.J. App. Div. 2019) which held that an ambulatory facility cannot be reimbursed for an unlisted code. The case notes that the omission "provides a clear indication of the Department's intent not to reimburse ACS" for omitted codes or where a CPT code is listed but no amount is stated.

However, New Jersey Manufacturers is not controlling. When a code is not listed or an amount for the service is not stated, the code can be "crosswalked" with a code for a comparable service. The ever-evolving nature of medicine and principles of equity would require fair reimbursement. This arbitrator is relying on the prior research and analysis of Arbitrator Meryem Toksoy in Dynamic Surgery Center, LLC v. Geico, AAA Case No. 17-18-1096-6679 (December 12 2019). She noted:

> To be clear: codes can be crosswalked. In response to an inquiry about reimbursement for new (and unlisted) AMA codes, the Department offered the following answer:
>
> > Question:
> > The CPT code for the service I want to perform in an ASC has been changed since the fee schedule rule was adopted. Are the insurance companies correct in saying that if I bill the new code, the ASC facility fee for the service is not reimbursable because that code is not on the ASC fee column Exhibit 1?
> > Answer:
> > Please bring these cases to the attention of the Department and we will determine if the old codes for the service can be crosswalked to the new codes. Codes can be crosswalked when the service described by the new code is substantially the same as that for the old code and Medicare still permits the service to be performed in an ASC. The fees for crosswalked services are those for the old codes.
>
> See: https://www.state.nj.us/dobi/pipinfo/medfeeqa_130104.htm#6 [Last visited on 11-02-19].

Support for this can also be found in NJAC § 11:3-29.4(e): The same provisions requires that services be billed with current AMA codes:

> [T]he provider shall always bill the actual and correct code found in the most recent version of the American Medical Association's Current Procedural Terminology . .

Therefore, an Applicant is entitled to reimbursement for a comparable service if said service is not listed specifically listed. Respondent then relies on the 33rd Amendment to the 11 NYCRR Part 68 [Regulation 83] which states as follows:

> (a)(1)If a professional health service reimbursable under Insurance Law 5102 (a)(1) is performed outside this State, the amount that the insurer shall reimburse for the service shall be the lower of the amount charged by the provider and the prevailing fee in the geographic location of the provider with respect to services:
> (i) that constitute emergency care;
> (ii) provided to an eligible injured person that is not a resident of this State; or
> (iii) provided to an eligible injured person that is a resident of this State who, at the time of treatment, is residing in the jurisdiction where the treatment is being rendered for reasons unrelated to the treatment.
> ….
> (b) Except as provided in subdivision (a) of this section, if a professional health service reimbursable under Insurance Law section 5102 (a)(1) is performed outside this State with respect to an eligible injured person that is a resident of this State, the amount that the insurer shall reimburse for the service shall be the lowest of:
> (1) the amount of the fee set forth in the region of this State that has the highest applicable amount in the fee schedule for that service;
> (2) the amount charged by the provider; and (3) the prevailing fee in the geographic location of the provider.
>
> …

In this case, the Assignor was a New York resident who received treatment in New Jersey. Therefore, the proper fee would be the lower of the fee set forth in New York (in the region with the highest amount) or the amount under the New Jersey Fee Schedule which can be determined through a crosswalk with a comparable service.

The two parties have submitted three different calculations of proper fee schedule. The Applicant has submitted a document entitled Independent Healthcare Consultation Opinion which crosswalks facility fee code for G 62321 to new codes under NJ Fee Schedule. The Applicant has also submitted a report from Julia Healthcare Consulting which crosswalk these codes to the codes listed under Healthcare Common Procedure

Coding System (HCPCS) for Medicare & Medicaid patients. The problems with these two reports is that the first did not directly address the codes in this proceeding; while the second did not review other codes in New Jersey but looked toward Medicare & Medicaid codes. Further, neither report referenced the New York State codes for this New York State resident/

The Respondent has submitted a report from its Support Claims Division that calculated the New York facility fee for these ambulatory procedures. Effective 10/01/15, payment for ambulatory surgical services is to be made in accordance with enhanced ambulatory patient groups (EAPG) methodology, 12 NYCRR 329-2.1. An APG is "a defined group of outpatient procedures, encounters or ancillary services, as specifically identified and published by the Department of Health, which reflect similar patient characteristics and resource utilization and which incorporate the use of ICD-10-CM diagnosis codes and CPT-4 and HCPCS procedure codes…"12 NYCRR 329-2.2(a). The appropriate fee is determined by "APG computer software developed and published by Minnesota Mining and Manufacturing Corporation (3M) to process CPT-4 and ICD-10 code information in order to assign patient visits to the appropriate APG category or categories and apply appropriate bundling, packaging and discounting to assign the appropriate final APG weight and associated reimbursement" 12 NYCRR 329-2.1(h).

The Respondent's audit calculated $1,428.99 for the CPT 64633 with no reimbursement for the two units of CPT 64634 with the following notations:

> Significant procedure Consolidation (refers to the collapsing of multiple related significant procedure APG's into a single EAPG for the purpose of determining payment) based on the New York Enhanced Ambulatory Patient Grouping (EAPG) Methodology
> This charge has been evaluated using the bilateral guidelines from the New York Enhanced Ambulatory Patient Grouping (EAPG) Methodology
> The New York State Workers' Compensation Board adopted the 3M Enhanced Ambulatory Patient Groups (EAPG) software preference and Edits to facilitate payment. The submitted National Provider Identification (NPI) number is not found in the New York Department of Health's Ambulatory Patient Group (APG) Rates. The Generic Upstate or Downstate facility values was used to calculate the EAPG payment.

As a finding of fact, the Respondent has submitted the only proper calculation for EAPG payment using 3M software under the New York Fee Schedule.

Once a Carrier has established that the amounts billed were in excess of the fee schedule, the burden shifts to the provider to show that establish a different interpretation, miscalculation or error. Cornell Medical P.C. v. Mercury Casualty Co., 24 Misc. 3d 58, (App Term 2d, 11th & 13 Dist. 2009). Applicant is awarded reimbursement of $1,428.99.

Pursuant to 11 NYCRR 65-4.5 (o)(1)(i)(ii), an arbitrator is the judge of the relevance and materiality of the evidence offered.

Interest. The insurer shall compute and pay to the Applicant the amount of interest from the filing date of the Request for Arbitration, at a rate of 2% per month, simple interest (i.e. not compounded) using a 30-day month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

Attorney's Fees. As said case was filed on or after February 4, 2015, Applicant is awarded attorney's fees for the total amount of first party benefits awarded. Pursuant to 11 NYCRR 65-4.6(d)(e), the Applicant is awarded 20 percent of the amount of the first party-benefits, with no minimum fee and a maximum $1,360.00 which is the total amount awarded one Applicant in one action from one provider. See: LMK Psychological Services, P.C. v. State Farm Mut. Auto Ins. Co., 46 A.D.3d 1290; 849 N.Y.S.2d 310 (3 Dept. 2007).

APPLICANT IS AWARDED REIMBURSEMENT OF $1,428.99, TOGETHER WITH INTEREST AND ATTORNEYS' FEES.

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 | Status |
|---|---|---|---|---|
| | **Accelerated Surgical Center of North Jersey** | **12/01/18 - 12/01/18** | **$5,172.64** | **Awarded: $1,428.99** |
| **Total** | | | **$5,172.64** | **Awarded: $1,428.99** |

B. The insurer shall also compute and pay the applicant interest set forth below. 05/24/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest. The insurer shall compute and pay to the Applicant the amount of interest from the filing date of the Request for Arbitration, at a rate of 2% per month, simple interest (i.e. not compounded) using a 30-day month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

C. Attorney's Fees

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

Attorney's Fees. As said case was filed on or after February 4, 2015, Applicant is awarded attorney's fees for the total amount of first party benefits awarded. Pursuant to 11 NYCRR 65-4.6(d)(e), the Applicant is awarded 20 percent of the amount of the first party-benefits, with no minimum fee and a maximum $1,360.00 which is the total amount awarded one Applicant in one action from one provider. See: LMK Psychological Services, P.C. v. State Farm Mut. Auto Ins. Co., 46 A.D.3d 1290; 849 N.Y.S.2d 310 (3 Dept. 2007).

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 Orange

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

06/14/2020
(Dated)

Kent Benziger

**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:**
053ed9dfcad21e32327c0d9e9f4f6e4d

**Electronically Signed**

Your name: Kent Benziger
Signed on: 06/14/2020