

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Advanced Comprehensive Laboratory LLC
d/b/a TopLab
(Applicant)

- and -

American Country Insurance Company
(Respondent)

AAA Case No.	17-19-1136-5749
Applicant's File No.	00042460
Insurer's Claim File No.	63CBLG18000382
NAIC No.	38237

ARBITRATION AWARD

I, Kevin R. Glynn, 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 07/17/2020
Declared closed by the arbitrator on 07/17/2020

Mikhail Guseynov, Esq. from Drachman Katz, LLP participated in person for the Applicant

Edleene A. Pierre, Esq. from Law Office of Jason Tenenbaum, PC participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 3,750.00**, 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

The Assignor, AC-R, is a 37yo male passenger who was injured when involved in a motor vehicle accident on 1/8/18. AC-R suffered injuries which resulted in his seeking treatment. In dispute is Applicant's claim for a drug screen (80100) and ZLPT drug test (80102) performed on 4/8/18, in the total amount of \$3,750.00. The claim was denied based on a peer review report by Dr. Ajendra Sohal, M.D., dated 5/24/18. Therefore, there is an issue regarding the medical necessity of the claim and if necessary, there is an additional issue regarding the proper reimbursement.

4. Findings, Conclusions, and Basis Therefor

This case was 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. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived.

I find that Applicant established a prima facie case of entitlement to reimbursement for its claim. Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). Furthermore, I find that Respondent timely denied the claim.

To support a lack of medical necessity defense Respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219(U) (App. Term 2, 11 and 13 Jud. Dists. 2014). Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to Applicant. See generally, Bronx Expert Radiology, P.C. v. Travelers Ins. Co. 2006 NY Slip Op 52116 (App Term 1st Dept. 2006). The Appellate Courts have not clearly defined what satisfies this standard except to the extent that "bald assertions" are insufficient. Amherst Medical Supply, LLC v. A Central Ins. Co., 2013 NY Slip Op 51800(U) (App. Term 1st Dept. 2013). To meet the burden of persuasion regarding medical necessity - in the absence of factually contradictory records - the applicant must submit a rebuttal which meaningfully refers to and rebuts the assertions set forth in the peer review report. See generally, Pan Chiropractic, P.C. v Mercury Ins. Co., 24 Misc 3d 136[A], 2009 NY Slip Op 51495[U] [App Term, 2d, 11th & 13th Jud Dists 2009].

Respondent failed to submit the peer review report upon which its denial was based. Instead, Respondent submitted an orthopedic surgeon IME report by Dr. J. Serge Parisien, M.D., dated 5/21/18. Accordingly, Respondent has failed to sustain its medical necessity defense.

Fee Schedule

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 Op 26240, 12 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that an Applicant's claims were in excess of the appropriate fee schedule, Respondent's defense of noncompliance with the appropriate fee schedule cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curiam, 2006).

Respondent relies on the fee schedule Affidavit by Jeffrey Futoran, CPC, dated 7/6/20. Mr. Futoran opines:

...17. Assignee's Laboratory report documents the client as
Dynamic Surgery Center.

18. Assignee's laboratory report documents, the lab work was outsourced or referred to Advanced Comprehensive Laboratory / TOP LAB by Dynamic Surgery Center client ASC.

19. Assignee's Laboratory report documents the specimen was analyzed (4/10/2018) two days after the surgical procedure (4/8/2018)

20. The New York Department of Financial Services' FAQ publication states the 33rd Amendment to Regulation 83 (11 NYCRR 68.6) is effective for dates of service occurring on or after 1/23/2018 irrespective of accident date. See Exhibit B. The changes effected by the 33rd Amendment to Regulation 83 would be applicable to claims with a date of service occurring on or after January 23, 2018. If a claim contains dates of service which are both prior to and after January 23, 2018, the portion of the claim incurred prior to that date would not be subject to the 33rd Amendment to Regulation 83, irrespective of the date of accident, or the date the bill was received by the insurer..

21. 11NYCRR 68.6(a) states: (a)(1) If a professional health service reimbursable under [section 5102(a)(1) of the] Insurance Law section 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. (2) For purposes of this subdivision, emergency care means all medically necessary treatment initiated within 48 hours of a motor vehicle accident for a traumatic injury or a medical condition resulting from the accident, which injury or condition manifests itself by acute symptoms of sufficient severity such that absence of immediate attention could reasonably be expected to result in: death; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. Medically necessary treatment shall include immediate pre-hospitalization care, transportation to a hospital or trauma center, emergency room care, surgery, critical and acute care. Emergency care extends during the period of initial hospitalization until the patient is discharged from the hospital.

22. 11NYCRR 68.6(b) and (c) states: (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. (c) If the jurisdiction in which the treatment is being rendered has established a fee schedule for reimbursing health services

rendered in connection with claims for motor vehicle-related injuries and the fee schedule applies to the service being provided, the prevailing fee amount specified in subdivisions (a) and (b) of this section shall be the amount prescribed in that jurisdiction's fee schedule for the respective service."

23. Per 11 NYCRR 68.6 Assignee did not render services within 48 hours of the MVA date and the rendered service(s) do not constitute emergence care. Per 11 NYCRR 68.6 (b) the amount the insurer shall reimburse for the service shall be the lowest of: (1) highest applicable amount in the NY WCB fee schedule (2) Assignee's charge (3) Assignee's geographic fee

24. The 11 NYCRR 68.6(b)(2) amount (Assignee's charge) totals \$3,750.00.

25. Per 11 NYCRR 68.6(c), Assignee's 11 NYCRR 68.6(b)(3) amount is calculated under the New Jersey Department of Banking and Insurance Division of Property and Casualty's medical fee schedule for Personal Injury Protection coverage. See Exhibit C.

26. The following sources were reviewed to calculate the prevailing fee in the geographic location of the provider: New Jersey Administrative Code and New Jersey medical fee schedules (effective for treatment rendered on or after January 4, 2013) appendices and protocols to determine if the submitted charges for reimbursement are accurate.

27. The fee schedule categorizes reimbursement based on assignment to geographic regions by zip code. The Assignee provider rendered services within zip code 07061 and is deemed to reside in the North Region per N.J.A.C. 11:3-29.3(a)(2). All calculations will therefore utilize the Physician North Region reimbursement rate.

28. As documented above, Integrated Specialty Surgery Center has outsourced lab testing to the Assignee.

29. N.J.A.C § 11:3-29.5(a)(4) States § 11:3-29.5 ASC facility fees; hospital outpatient surgical facility fees (a) ASC facility fees are listed in Appendix, Exhibit 1, by CPT code. Codes that do not have an amount in the ASC facility fee column are not reimbursable if performed in an ASC. The ASC facility fees include services that would be covered if the services were furnished in a hospital on an inpatient or outpatient basis, including: 4. Diagnostic and therapeutic items and services. Appendix, Exhibit 1 indicates those CPT codes that, according to Medicare (see: www.cms.gov/ASCPayment/ASCRN/list.asp, CMS- 1504-FC, Exhibit AA) are considered ancillary services that are integral to surgical procedures and are not permitted to be reimbursed separately in an ASC. Appendix, Exhibit 7 indicates those services that, according to Medicare (see: https://www.cms.gov/HospitalOutpatientPPS/Downloads/CMS1506FC_Addendumdf) are considered ancillary services to surgical procedures and are not permitted to be reimbursed separately in a HOSF;

30. Per the above regulation, ASC's are not separately reimbursed for diagnostic toxicology / drug testing. The service and its fee are incorporated into the underlying ASC procedure code (ie surgery codes reported by Dr. Abbatematteo. CPT 64493, 64494 and 64495 facet injections).

31. It should also be noted, CPT codes 80100 and 80102 do not appear in the ASC column of the fee schedule.

32. N.J.A.C § 11:3-29.5(a) and NJ case law hold CPT codes without a listed charge in the ASC column of the fee schedule are non-reimbursable. See New Jersey Manufacturers Insurance Company v. Specialty Surgical Center of North Brunswick.

33. Per the above analysis, the 11 NYCRR 68.6(b)(3) amount totals \$0.00 as the diagnostic services (drug testing) are not separately reimbursed but are incorporated into the ASC facility fee of the reported surgery fee (CPT 64493, 64494, 64495).

34. 11 NYCRR 68.6(b)(1) requires a computation of the "highest applicable amount in the NY WCB fee schedule."

35. As stated above, the services were outsourced by an ASC.

36. The NY WCB adopted an Ambulatory Surgery Fee Schedule based on the Ambulatory Patient Groups (APG) system effective October 1st, 2015. A copy of the notice is annexed as Exhibit B.

37. The Workers' Compensation Board issued comments stating the new fee schedule will not be posted and that stakeholders may calculate payments either through the use of the 3M Grouper software, or manually (/content/main/SubjectNos/sn046_829.jsp). A copy of the comments is annexed as Exhibit C.

38. NY's EAPG fee schedule also includes lab work as part of the overall procedure fee.

39. I have been trained to operate and currently maintain a subscription of the 3M Grouper software.

40. Pursuant to the above instructions and comments provided by the New York Workers' Compensation board, the revenue, CPT and HCPCS codes with their respective charges were inputted into the 3M Grouper software.

41. It should be noted CPT codes 80101 and 80102 were retired by the AMA CPT book effective 1/1/2015. Current 2017 CPT codes 80305 and 80307 was imputed for retired qualitative (presence) and quantitative drug testing codes to calculate a EAPG fee.

42. It should be noted New York case law states reliance on the AMA CPT Book and AMA CPT Assistant is proper when interpreting fees under the WCB Fee Schedule. See Matter of Global Liberty Ins. Co. v McMahon, 2019 NY Slip Op 03692.

43. AMA CPT Book limits the reporting of CPT 80305 and 80307 to one unit per DOS. Annexed as Exhibit F is a copy of the AMA CPT Book instructions.

44. The downstate ASC schedule was selected to calculate the highest facility fee amount.

45. The 3M Grouper software calculated a total EAPG reimbursement fee of \$1030.11 fee for the facet injection and drug testing codes. A copy of the report is annexed as exhibit B.

46. Assignee's downstate ASC drug testing fee totals \$50.33.

47. Per the above analysis, Assignee's NY WCB EAPG fee totals \$33.55.

48. Per the above analysis, the 11 NYCRR 68.6(b)(1) amount totals \$33.55.

49. Per 11 NYCRR 68.6(b), the out of state health service is reimbursed \$0.00 as it is the lowest of the 68.6(b)(1), (2) and (3) amounts.

50. To date, Assignee received \$0.00 towards the \$0.00 fee leaving a balance of \$0.00.

Applicant argues that Mr. Futoran's analysis was flawed because the services at issue were performed in a laboratory and not an ASC. However, Applicant fails to submit any fee coder affidavit, audit or report to support this position. I find that Mr. Futoran's un rebutted analysis is competent evidentiary proof that Applicant is not entitled to any reimbursement pursuant to the 11 NYCRR 68.6 (b). As such, Applicant's claim is dismissed.

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

08/12/2020

(Dated)

Kevin R. Glynn

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:
4e2ce01fdf12ea7973683c93db2c6c11

Electronically Signed

Your name: Kevin R. Glynn
Signed on: 08/12/2020