American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Hudson Regional Hospital (Applicant)	AAA Case No.	17-19-1123-9758
	Applicant's File No.	00035482
- and -	Insurer's Claim File No.	1027962-01
	NAIC No.	16616
American Transit Insurance Company (Respondent)		

ARBITRATION AWARD

I, Eileen Hennessy, 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-G.E.

1. Hearing(s) held on 07/28/2020
   Declared closed by the arbitrator on 07/28/2020

   Mikhail Guseynov from Drachman Katz, LLP participated by telephone for the Applicant

   Dmitriy Dykman from American Transit Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 6,105.54**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated and agreed that (i) Applicant has met its prima facie burden by submitting evidence that payment of no-fault benefits is overdue, and proof of its claim was mailed to and received by Respondent and (ii) Respondent's denial of the subject claim was timely issued.

3. Summary of Issues in Dispute

   The record reveals that the Assignor-G.E., a 22-year-old female, claimed injuries as the driver of a motor vehicle involved in an accident on 4/17/2018. Applicant seeks reimbursement for drug testing billed in connection with lumbar facet injections

conducted on 12/1/2018. Respondent denied the claims based on a lack of medical necessity per the results of the peer review by Dr. Peter Chiu, M.D., dated 1/17/2019. The issues to be determined are 1) whether the drug testing was medically necessary and, if so, 2) whether the services were billed in accordance with the applicable fee schedule?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement for drug testing billed in connection with lumbar facet injections. This hearing was conducted using the documents contained in the Electronic Case Folders (ECF) for the two linked cases maintained by the American Arbitration Association. All documents contained in the ECFs are made part of the record of this hearing and my decision was made after a review of all relevant documents found in the ECFs as well as the arguments presented by the parties during the hearing.

In accordance with 11 NYCRR 65-4.5(o) (1), an arbitrator shall be the judge of the relevance and materiality of the evidence and strict conformity of the legal rules of evidence shall not be necessary. Further, the arbitrator may question or examine any witnesses and independently raise any issue that Arbitrator deems relevant to making an award that is consistent with the Insurance Law and the Department Regulations.

Respondent withdrew their Worker's Compensation defense premised on the decision in *State of New York - Workers' Compensation Board In regard to [Assignor-G.E.]*, WCB Case #G214 7253, which found "At the Workers' Compensation hearing held on 05/07/2019 involving the claim of [Assignor-G.E.] at the Manhattan hearing location, Judge Barry Hermelee made the following decision, findings and directions: DECISION: Claim is disallowed. The claimant was not involved in a "covered service"; and was not within the scope and/or course of his employment at the time of the accident in issue. The case is closed". Respondent is defending the claim premised on lack of medical necessity and fee schedule.

Legal Standards for Determining Medical Necessity

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 2nd, 11th and 13th 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 issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, Kingsbrook Jewish Medical Center v. Allstate Ins. Co., 61 A.D.3d 13, 871 N.Y.S.2d 680 (2d Dept. 2009), such as by a qualified expert

performing an independent medical examination or conducting a peer review of the injured person's treatment. *See* Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp., 2003 N.Y. Slip Op. 50842(U), 2003 WL 21049583 (App. Term 2d & 11th Dists. Apr. 1, 2003). The appellate courts have not clearly defined what satisfies the insurer's evidentiary standard except to the extent that "bald assertions" are insufficient. Amherst Medical Supply, LLC v. A Central Ins. Co., 41 Misc.3d 133(A), 981 N.Y.S.2d 633 (Table), 2013 NY Slip Op 51800(U), 2013 WL 5861523 (App. Term 1st Dept. Oct. 30, 2013). However, there are myriad civil court decisions tackling the issue of what constitutes a "factual basis and medical rationale" sufficient to establish a lack of medical necessity. 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 Ins. Co., 7 Misc.3d 544, 547, 796 N.Y.S.2d 857, 860 (Civ. Ct. Kings Co. 2005); *See also*, All Boro Psychological Servs. P.C. v. GEICO, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012).

Where a respondent meets its burden, it becomes incumbent on the claimant to rebut the peer review. Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 139(A), 2008 WL 506180 (App. Term 2d & 11 Dists. Feb. 21, 2008); A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co., 16 Misc.3d 131(A), 2007 WL 1989432 (App. Term 2d & 11 Dists July 3, 2007. "[T]he insured/provider bears the burden of persuasion on the question of medical necessity. Specifically, once the insurer makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity, 'plaintiff must rebut it or succumb." Bedford Park Medical Practice, P.C. v. American Transit Ins. Co., 8 Misc.3d 1025(A), 2005 WL 1936346 at 3 (Civ. Ct. Kings Co., Jack M. Battaglia, J., Aug. 12, 2005). "Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity (*see* Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11 ed])." West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 2006 N.Y. Slip. Op. 5187(U) at 2, 2006 WL 2829826 (App. Term 2d & 11 Dists. Sept. 29, 2006).

Application of Legal Standards

The Assignor underwent drug testing in conjunction with lumbar facet injections conducted on 12/1/2018. In support of its contention that the services were not medically necessary, Respondent relies upon the peer review of Peter Chiu, M.D., dated 1/17/2019. Applicant submitted a formal rebuttal by Alexander Zhuravkov, M.D., dated 6/9/2020.

I find Dr. Chiu's peer review to be sufficient for the purpose of establishing the defense of lack of medical necessity. Dr. Chiu adequately sets forth the factual basis and medical

rationale to support his conclusion that the drug testing was not indicated for the assignor. That being so, the burden shifts to the Applicant to counter Respondent's showing.

I am faced with conflicting opinions concerning the medical necessity for the disputed testing herein. There are no legal issues to resolve. This dispute involves solely an issue of fact, that is, whether the testing was medically necessary. Resolution of that fact is determined by which opinion is accepted by the trier of fact.

Having carefully reviewed the evidence, including the rebuttal statement, dated 6/9/2020, the examination reports, dated 10/3/2018, 11/17/2018, and 12/1/2018 by Dr. Zhuravkov, and the lumbar facet injection operative report, dated 12/1/2018, I find, as a matter of fact, that the drug testing in dispute was medically necessary. The rebuttal and examination reports set forth the medical necessity for the drug testing that was performed based on the clinical findings of the Assignor. I find the reports and rebuttal sufficiently address the arguments that were raised in the peer review. Having carefully considered the entire record, I find that the more credible and persuasive proof resides with the Applicant. Therefore, the issue to be determined is whether the services were billed in accordance with the applicable fee schedule.

FEE SCHEDULE

To establish a prima facie showing of its entitlement to reimbursement, as a matter of law, Applicant must submit evidentiary proof that the prescribed statutory billing forms, setting forth the facts and the amount of the loss sustained, were mailed and received and that payment of no-fault benefits is overdue. *See* Mary Immaculate Hospital v. Allstate Ins. Co., 5 A.D.3d 742 (2004). With some limited exceptions, a No-Fault claim must be paid or denied within thirty days or it is "overdue." commencing the accrual of interest and attorney fees. *See*, N.Y. Ins. Law § 5106[a] (McKinney 2000); 11 NYCRR § 65[g][3]; Presbyterian Hospital v. Maryland Cas. Co., 90 N.Y.2d 274, 660 N.Y.S.2d 536 (1997).

It is well established that a healthcare provider must limit its charges according to the applicable fee schedule. Goldberg v. Corcoran, 153 AD2d 113, 117-18 (App Div, 2d Dept 1989). Amended Regulations section 65-3.8(g)(1) states 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: (i) when the claimed medical services were not provided to an injured party; or (ii) 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. This subdivision applies to medical services rendered on or after April 1, 2013.

Although a defense based on Fee Schedule, for services rendered on or after April 1, 2013, is now a non-precludable defense, it remains an insurer-Respondent's burden to establish that the fees charged by a provider-Applicant exceed the amounts set forth in the appropriate Fee Schedule. Liberty Chiropractic, P.C. v. 21 Century Ins. Co., 53 Misc. 3d 133(A), 2016 WL 5921834 (Table), 2016 N.Y. Slip Op. 51409(U)(App. Term,

2d, 11 and 13 Jud. Dists. 2016)(*citing* Rogy Med., P.C. v. Mercury Cas. Co., 23 Misc.3d 132(A), 885 N.Y.S.2d 713 (Table)(App. Term, 2d, 11 and 13 Jud. Dists. 2009). *See also* Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 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 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. *See* Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1 Dep't, per curiam, 2006). A respondent may interpose a defense in a timely denial that the claim exceeds the fees permitted by the Workers' Compensation schedules, but respondent must, at minimum, establish, by evidentiary proof, that the charges exceeded that permitted by law. Abraham v. Country-Wide Ins. Co., 3 Misc.3d 130A, 787 N.Y.S.2d 678, 2004 N.Y. Misc. LEXIS 544 (App. Term, 2d Dept. 2004).

An insurer's unilateral decision to re-code or change a medical provider's billed CPT codes, to reimburse disputed medical services at a reduced rate, or to deny a claim in its entirety, is ineffectual when unsupported by a peer review report or by other proof setting forth a sufficiently detailed factual basis and medical rationale for the code changes, fee reductions and denials. *See* Amaze Medical Supply v. Eagle Insurance Company, 2 Misc. 3d 128A (App Term 2d and 11th Jud Dist 2003). A lay person is not qualified to evaluate the CPT codes or to change if the code is used by a health provider in its bills. *See* Abraham v. Country-Wide Ins. Co., 3 Misc. 3d. 130A (App. Term 2d. Dept. 2004). Once the insurer establishes a prima facie showing that the amounts charged by a provider were in excess of the fee schedule, the burden shifts to the provider to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. Cornell Medical, P.C. v. Mercury Casualty Co., 24 Misc. 3d 58, 884 N.Y.S.3d 558 (App. Term 2d, 11th &13th Dists. 2009).

Judicial notice of the New Jersey Fee Schedule is taken. *See*, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 20 (2d Dept. 2009); LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A) (App Term 2d, 11th & 13th Jud Dists. 2011); Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A) (App Term, 1st Dept. 2011).

ANALYSIS

Applicant billed CPT code 80305 ($179.46) in addition to 20 classes of drugs (CPT 80324, 80359, 80332, 80335 80346, 80368, 80369, 80348, 80354, 80358, 80360, 80361, 80365, 80362, 80372, 80373, 80355, 80356, 80345 and 80366) billed at $269.37 each for a total of $6,105.54. In addition to the peer review, Respondent also denied the claim premised upon the fee schedule.

Judicial notice of the New York and New Jersey Fee Schedules is taken. *See*, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 20 (2d Dept. 2009);

LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A) (App Term 2d, 11th & 13th Jud Dists. 2011); Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A) (App Term, 1st Dept. 2011).

The service in dispute was provided to a New York resident and was performed in New Jersey. 11 NYCRR §68.6, effective on January 23, 2018, 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.

Respondent submits an Explanation of Benefits asserting that Applicant's claim was denied pursuant to 11 NYCRR § 68.6.Respondent submitted the affidavit of Elisha Jones, a fee audit specialist. According to Ms. Jones, the New Jersey fee schedule applies. Respondent indicates that the claim is not reimbursable "as the CPT codes are not listed in the NJ Medical Fee Schedule" and "Based on the CPT code the amount submitted exceeds the fee schedule". Respondent's EOB does not sufficiently establish that Applicant is not entitled to any reimbursement for this claim. However, upon review of Applicant's claim and the fee schedules, it is evident that the claim is billed in excess of even the highest applicable fee within the NY or NJ Fee schedule, and reimbursement at the charged amount is not proper pursuant to 11 NYCRR §68.6.

Regarding New York, according to the Official New York Workers' Compensation Medical Fee Schedule, Pathology and Laboratory Fee Schedule, Ground Rule 4, "When urine drug screening is performed in an office setting using a quick or rapid screening test method utilizing a stick/dip stick, cup or similar device, reimbursement shall be limited to one unit of 80101 for a single drug class OR 80104 for two or more drug classes regardless of the number of drug classes tested or reported per date." According to the report, the test was a rapid screening test method utilizing a stick/dipstick.

I take judicial notice of Ground Rule 4 of the Pathology and Laboratory Fee Schedule. Applicant has not established that the drug testing billed was exempt from Ground Rule 4. The report is labeled "Urine toxicology cups visual reading", indicating the test was performed in an office utilizing a dipstick. The results indicate "positive" or "negative" for all drug classes in the results, which are qualitative, indicating the provider has "performed a screen analysis for multiple drugs or drug classes for opioid monitoring",

which should have been billed using 80104 for a qualitative screen analysis, which has a total allowable reimbursement rate of $35.19 for Region IV, the highest allowable rate in New York. The Assignor tested positive for one of class of drugs, oxycodone, which was prescribed according to the medical records, and did not need to be confirmed. The remaining lab results are negative consistent and confirmation codes are not required.

I concur with the well-reasoned award of Arbitrator Nada Saxon in Hudson Regional Hospital and Country-Wide Insurance Company, AAA Case No. 17-18-1115-1465, which addresses the proper reimbursement for the services in accordance with the New York Fee Schedule. The decision held, in pertinent part:

> *The codes billed (and their descriptors) appear in the NYS WC Fee schedule, effective 4/1/19, however, this claim predates that and those reimbursement rates have not yet taken effect in the realm of no-fault. The codes billed are not found within the currently applicable fee schedule. Nonetheless, I do not find outright denial of Applicant's claim pursuant to 11 NYCRR § 68.6 and 11 NYCRR 65-3.8 (g) (1) (ii) proper in this instance. Upon review of the pathology and laboratory section of applicable fee schedule, which is assigned a conversion factor of 1.19, the highest relative value for a drug screen is 29.57 (CPT 80104), i.e. a reimbursement rate of $35.19. The general value for "drug confirmation, each procedure" is 30.81 (CPT 80102), i.e. a reimbursement rate of $36.66.*
>
> *Furthermore, comparing some of the named substances Applicant tested with the existing fee schedule reveals a relative value of 30.81 or less. For example, Applicant billed CPT 80324, described as amphetamines; 1 or 2 under the 4/1/19 Pathology and Laboratory Medical Fee schedule; under the current fee schedule, that same substance is listed in the Pathology and Laboratory Medical Fee Schedule under CPT 82145 with a RVU of 30.81. Barbiturates (CPT 80345 in the 4/1/19 fee schedule and CPT 82205 in the current fee schedule) have a RVU of 24.64. As such, Applicant's billing is clearly in excess of any plausible amount under the applicable NY fee schedule.*
>
> *Additionally, I am persuaded by Arbitrator Miller's award in Hudson Regional Hospital v. Allstate Fire & Casualty Insurance Company, AAA: 17-18-1114-2495 (7/22/20), which involved the exact same Applicant and the same codes and total billed amount. Respondent therein submitted a fee coder affidavit by Carolyn Mallory CPC, who reviewed the billing and the codes and advised they were not found in the current applicable New York Fee Schedule, but found that the drug screen billed as CPT 80305 had the highest reimbursable value of $35.19 and the remainder of the drug confirmation testing (CPT 80324, 80359, 80332, 80335 80346, 80368, 80369, 80348, 80354, 80358, 80360, 80361, 80365, 80362, 80372, 80373, 80355, 80356, 80345 and 80366) had RVUs ranging from 21.56 to 30.81. It was concluded the lowest reimbursable rate was that set forth in the NY fee schedule.*

Regarding the NJ Fee Schedule, the CPT book states: "when reporting codes for services provided, it is important to assure the accuracy and quality of coding through verification of the intent of the code by use of the related guidelines, parenthetical instructions, and coding resources, including the CPT assistant…"

According to the New Jersey Medical Fee schedule Guidelines when a CPT, CDT or HCPCS codes for the service performed has been changed since the fee schedules last amended, the provider shall always billed the actual correct code found in most recent version of the American Medical Association's (AMA) current procedural terminology or American Dental Association's (ADA) current dental terminology.

CPT 80305, a code not listed in the New Jersey Fee Schedule, is described as "Drug test(s), presumptive, any number of drug classes, qualitative; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipstick, cups, cards, cartridges) includes sample validation when performed, per date of service (maps to 80300 or G0477).".

According to the Center for Medicare & Medicaid Services (CMS), relied on by the NJAC:

> Current coding for testing for drugs of abuse relies on a structure of "screening" (known as "presumptive" testing) and "quantitative" or "definitive" testing that identifies the specific drug and quantity in the patient.
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> Beginning January 1, 2017, presumptive drug testing may be reported with CPT codes 80305- 80307. These codes differ based on the level of complexity of the testing methodology. Only one code from this code range may be reported per date of service:
> The descriptors for Presumptive Drug Testing codes are:
> · 80305: Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg, immunoassay) capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.
> · 80306: Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg, immunoassay) read by instrument-assisted direct optical observation (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.
> · 80307: Drug tests(s), presumptive, any number of drug classes, qualitative, any number of devices or procedures; by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service.

As mentioned in the National Correct Coding Initiative Policy Manual, Chapter 10, Section E, beginning January 1, 2016, definitive drug testing may be reported with HCPCS codes G0480-G0483. These codes differ based on the number of drug classes including metabolites tested. Only one code from this code range may be reported per date of service.
The descriptors for Definitive Drug Testing codes are:
· G0480: Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 1-7 drug class(es), including metabolite(s) if performed
· G0481: Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and MLN Matters SE18001 Related CR N/A Page 3 of 4 mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es), including metabolite(s) if performed
· G0482: Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed
· G0483: Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to

GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class(es), including metabolite(s) if performed.

…

The work performed in this test approximates the work performed in CPT code 80307. Providers performing validity testing on urine specimens utilized for drug testing shall not separately bill the validity testing. For example, if a laboratory performs a urinary pH, specific gravity, creatinine, nitrates, oxidants, or other tests to confirm that a urine specimen is not adulterated, this testing is not separately billed.

According to the New Jersey Fee Schedule, Frequently Asked Questions:

Q. The CPT code for the procedure I performed is not on the fee schedule. What should I bill?

A. The recent amendments to the Physicians' fee schedule include around 1,000 procedures. However, there will be some procedures that are not included. The text of the rule at N.J.A.C. 11:3-29.4(e) states that:

(e) Except as noted in (e)1 and 2 below, the insurer's limit of liability for any medical expense benefit for any service or equipment not set forth in or not covered by the fee schedules shall be a reasonable amount considering the fee schedule amount for similar services or equipment in the region where the service or equipment was provided or, in the case of elective services or equipment provided outside the State, the region in which the insured resides. Where the fee schedule does not contain a reference to similar services or equipment as set forth in the preceding sentence, the insurer's limit of liability for any medical expense benefit for any service or equipment not set forth in the fee schedules shall not exceed the usual, customary and reasonable fee.

1. For the purposes of this subchapter, determination of the usual, reasonable and customary fee means that the provider submits to the insurer his or her usual and customary fee. The insurer determines the reasonableness of the provider's fee by comparison of its experience with that provider and with other providers in the region. The insurer may use national databases of fees, such as those published by *Ingenix* (www.ingenixonline.com)or *Wasserman* (www.medfees.com), for example, to determine the reasonableness of fees for the provider's geographic region or zip code.

2. All applicable provisions of this section concerning billing and payment apply to fees for services provided outside of New Jersey and to fees that are not on the fee schedule.

> The recent Appellate Division decision, August 10, 2009, Docket number A-0344-07T3, stated that for determinations of UCR for treatment rendered August 10 and after, the Ingenix database should not be used as one of the national databases mentioned in the rule for determining UCR until the Department reviews it. The Department notes that the Appellate Division decision does not affect any determinations of UCR for treatments rendered prior to August 10, 2009."

Applicant incorrectly reported CPT Codes: CPT 80324, 80359, 80332, 80335 80346, 80368, 80369, 80348, 80354, 80358, 80360, 80361, 80365, 80362, 80372, 80373, 80355, 80356, 80345 and 80366)in addition to code 80305.

All codes billed are inclusive to CPT code 80305, and when lab results are negative consistent, confirmation codes are not required. As an initial note, the prescription does not contain a doctor's signature. On the prescription, under individual test orders, 12 drug names are prescribed as point of care, to confirm both positive and negative results, yet 20 drugs were tested. One category of drugs was initially positive, which was prescribed and therefore did need to be confirmed.

Furthermore, according to the New Jersey Fee Schedule Guidelines an "eligible charge or expense" means the usual, customary and reasonable charge as determined pursuant to the New Jersey Code. The bill is inappropriately coded as the medical treatment or diagnostic test must be consistent with the clinically supported symptoms, diagnosis, or indications of the injured person; is the most appropriate level of service that is in accordance with the standards of good practice; that the treatment is not primarily for the convenience of the injured person or provider; that the treatment is not necessary; and that the treatment does not include unnecessary testing.

According to the prescription, Dr. Beshara ordered drug testing for multiple classes of drugs. This testing is covered under the description of presumptive drug testing under code 80305, which can be billed once per day and is inclusive of the remaining codes billed. *See* CPT Assistant. March 2017; Volume 27: Issue 3, Presumptive Drug Class Screening Changes, Code 80305, which represents all presumptive procedures by direct optical observation, is "**to be reported only once per date of service, *irrespective of the number of procedures performed or drugs tested***". (Emphasis added). Therefore, there is no support for the extensive codes billed. Furthermore, Applicant conducted multiple tests that were not prescribed.

As Arbitrator Weisman noted in Excell Clinical Lab v. Geico, AAA No.: 17-19-1127-2500 (2/1/20), "I am not convinced that during the interim period between 2012 and 2018, when there was less clarity regarding the appropriate rates of

reimbursement for each of the CPT codes billed by applicant, that the fee schedule contemplated that a healthcare provider could obtain excessive reimbursement as billed by the applicant for urine drug screening."

Therefore, CPT code is 80305 is payable, which is inclusive of multiple drug classes that are tested on a single day using direct optical observation. According to the Clinical Diagnostic Laboratory Fee Schedule for 2018, the following is the appropriate reimbursement under Medicare and the NJAC:

(Screenings/Presumptive)

80305 $13.46

80306 $17.96

80307 $71.83

(Confirmations/Definitive)

G0480 (1-7) $114.43

G0481 (8-14) $156.59

G0482 (15-21) $198.74

G0483 (22 &>) $246.92

Therefore, according to the New Jersey Fee Schedule, Applicant would be entitled to $13.46 for code 80305. According to the New York Fee Schedule, the maximum reimbursable amount would be $35.19.

After comparing the relevant evidence, reviewing the CPT codes and taking judicial notice of the fee schedules, I find Applicant's claim is billed in excess of any plausible fee schedule amount set forth in the applicable NY and NJ fee schedule. As such, I am constrained to limit the award in accordance with the applicable laws and regulations. Pursuant to the regulations, Applicant's claim should be reduced to the highest applicable fee in the NY Fee schedule, i.e. $35.19.

Accordingly, Applicant's claim is granted in the amended amount of $35.19. The remainder of the claim is denied. This award is in full disposition of all No-Fault benefit claims submitted to this Arbitrator.

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**
	Hudson Regional Hospital	**12/01/18 - 12/01/18**	**$6,105.54**	**Awarded: $35.19**
Total			**$6,105.54**	**Awarded: $35.19**

B. The insurer shall also compute and pay the applicant interest set forth below. 03/25/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. *See generally*, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30-day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." *See*, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009). Based on the regulations, interest shall accrue from the date the applicant requested arbitration in this matter. *See*, 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

Applicant is entitled to an attorney's fee pursuant to Insurance Law §5106(a). After calculating the sum total of the first-party (No-Fault) benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, subject to the following limitations: In the event the above filing date was prior to Feb. 4, 2015, the attorney's fee is subject to a minimum of $60.00 and a maximum of $850.00, per 11 NYCRR 65-4.6(e). In the event the above filing date was on or after Feb. 4, 2015, the attorney's fee is subject to a maximum of $1,360.00, per 11 NYCRR 65-4.6(d). In the event the above filing date was on or after Feb. 4, 2015 and first-party (No-Fault) benefits are awarded to more than one Applicant herein, the attorney's fee shall be calculated separately for each Applicant, each Applicant's attorney fee being subject to the $1,360.00 maximum.

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

08/27/2020
(Dated)

Eileen Hennessy

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:
4e7cf81ebe76bd87d63d540696bc573a

Electronically Signed

Your name: Eileen Hennessy
Signed on: 08/27/2020