American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

All City Family Healthcare Center (Applicant)	AAA Case No.	17-19-1149-3635
	Applicant's File No.	BT19-104949
- and -	Insurer's Claim File No.	9TINY01299-02
	NAIC No.	29742
Integon National Insurance Company (Respondent)		

ARBITRATION AWARD

I, Samiya Mir, 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 09/29/2020
   Declared closed by the arbitrator on 11/17/2020

   Jason Behar from The Tadchiev Law Firm, P.C. participated in person for the Applicant

   John Rossillo from Rossillo & Licata LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 5,211.56**, 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

   This Arbitration stems from treatment of Assignor, a 27 year old female who was a passenger involved in a motor vehicle accident on January. In dispute are Applicant's claims for an IDET procedure that took place on June 17, 2019. The issues for determination are: 1) whether the services, which were denied based on a peer review of Dr. Dean, were medically necessary; and 2) whether Respondent maintained its fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

This award was decided on the basis of the arguments raised at the hearing and the documents submitted by the parties contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association.

As a threshold matter, Applicant has established its prima facie entitlement to first party no-fault benefits under Article 51 of the Insurance Law, by submitting evidentiary proof that the prescribed statutory billing forms were mailed to and received by the insurer and that payment of no-fault benefits are overdue. See Viviane Etienne Med. Care, P.C v. Country-Wide Ins., 2013 NY Slip Op. 08430 (2d Dep't 2013.) Once Applicant has made out a prima facie case, the burden shifts to Respondent to timely request additional verification, deny, or pay the claim. See Hospital for Joint Diseases v. Travelers Prop. Cas. Ins. Co., 9 N.Y.3d 312 (2007).

Medical Necessity

A lack of medical necessity is a defense to an action to recover assigned no fault benefits, which an insurer may assert upon a timely denial, based on a medical examination or a peer review report. See Rockaway Boulevard Medical P.C. v. Travelers Prop. Cas. Corp., 2003 N.Y. Slip. Op. 50842 (U), 2003 WL 21049583 (App. Term 2d Apr. 1, 2003).

In this case, Respondent timely denied the IDET procedure based on a peer review of Dr. Sammy Dean dated August 13, 2019. Dr. Dean reviewed the Assignor's records and noted that she had lower back pain, radiating to the bilateral lower extremities and buttocks with paresthesias, and was receiving chiropractic treatment, acupuncture, and physical therapy. Dr. Dean noted that the standard of care would be conservative care for 4-6 weeks and if that failed, or if there was a deterioration, subsequent further intervention may be indicated. He noted that in this case there was sufficient information, "documented in the clinical records which supports a diagnosis of lumbar radiculopathy and minimal effectiveness of conservative treatment." He agreed that the discectomy was medically necessary. He stated, however, that there was limited evidence to the medical necessity of the IDET. He noted that "there is some question as to the nature of the claimant's pain as chronic or refractory prior to the performance of the discectomy," and "no clear indication or rational" for the procedure. He noted that there was also no rational for the DME that was not at issue in this case.

Applicant submitted a rebuttal of Dr. Kotkes dated July 24, 2020. Dr. Kotkes noted that the Assignor had a lumbar percutaneous discectomy with IDET due to a diagnosis of lumbar intervertebral disc displacement and lumbar radiculopathy. He stated that "there are numerous studies which support the medical necessity of annuloplasty (IDET)." He noted that annuloplasty was found to be an effective and safe procedure to managing discogenic low back pain and a safe and minimally invasive therapy option. He cited to studies to support his analysis.

Dr. Dean submitted an addendum dated 8/14/20 where he stated that the IDET was not medically necessary. He stated that it is indicated for discogenic pain that is non-radicular and has not responded to conservative treatment. He also reiterated that its effectiveness remains unproven.

Analysis

It is Respondent's burden to prove its defense that services were not medically necessary. See A.B. Med. Servs., PLLC v. Lumbermens Mut. Cas. Co., 781 N.Y.S.2d 818, 818 (App.Term, 2d May 26, 2004); King's Med. Supply Inc. v. Country-Wide Ins., 783 N.Y.S.2d 448,452 (Civ.Ct.Kings Co. Oct. 19, 2004). To establish lack of medical necessity through a peer review report, the peer reviewer's opinion must set forth a factual basis and medical rationale for the lack of medical necessity defense, including evidence of medical standards. See Nir v. Allstate Ins.Co., 796 N.Y.S.2d 857 (Civ.Ct.Kings Co. Feb. 28, 2005). When a peer reviewer has insufficient documentation and information, the peer reviewer opinion lacks a factual basis and medical rationale sufficient to establish the defense of medical necessity. See MidIsland Medical, PLLC v. Allstate Ins. Co., 20 Misc. 3d 144 (A). The conclusory opinion of the insurer's expert is insufficient to meet the insurer's burden on the defense. See id. at 547; CityWide Soc. Work & Psych. Serv. PLLC v. Travelers Indem. Co., 777 N.Y.S.2d 241 (Civ. Ct.Kings Feb. 11, 2004).

If the insurer presents sufficient evidence establishing a lack of medical necessity, then the burden shifts back to the Applicant to present its own evidence of medical necessity. See Tremont Med. Diagnostic, P.C. v. Geico Ins., 824 N.Y.S.2d 759 (App.Term 2d Sept. 29, 2006). In order for the Applicant to prove that the disputed expense was medically necessary, it must meaningfully refer to, or rebut, the Respondent's evidence. See Yklik, Inc. v. Geico Ins. Co., 958 N.Y.S.2d 64 (App.Term 2d July 29, 2010).

I find that in this case, that the peer review of Dr. Dean was insufficient as to the IDET. The analysis regarding the IDET was brief and did not explain why in this case it was medically unnecessary. Dr. Dean seemed to indicate that its efficacy in general was questionable but did not give a standard of care or sufficiently explain his analysis in relation to this patient. Even if it was sufficient, I find that the rebuttal rebutted the peer review. Dr. Kotkes cited to studies that supported the IDET procedure as a safe and minimally invasive treatment for patients who have not responded to conservative treatment. I do not reach the addendum as the peer was insufficient but even if I did, it did not add enough substantive information regarding the standard of care or connection to the Assignor's findings to overcome the rebuttal. I find in favor of Applicant in line with the fee schedule defense below.

Fee Schedule

Respondent must demonstrate by competent evidentiary proof that applicant's claims were in excess of the appropriate fee schedules; otherwise respondent's defense of noncompliance with the appropriate fee schedule cannot be sustained. Continental Medical, P.C., v. Travelers Indemnity Co., 819 N.Y.S.2d 847 (App. Term 1st Dep't 2006).

Respondent raised a fee schedule defense, noting that Applicant should not be reimbursed under the fee schedule as the significant procedure, or the discectomy, was paid for, and the annuloplasty, billed under CPT code 22526 - 59 and 22527 - 59 should receive no reimbursement. Respondent submitted a fee coder affidavit of Jennifer

Communale, CPC. Ms. Communale noted that the significant procedure, the discectomy, billed under CPT code 62287, has an APG code of 28, and should be reimbursed at $5211.56 with a capital add on of $81.37. She stated that the procedure at issue in this case, however, billed under CPT Codes 22526 and 22527, which also have an APG of 28, "is inclusive to CPT code 62287." She stated that as per EAPG Guidelines, "significant procedure consolidation," all APG 28 assignments are inclusive to the reimbursement for APG 28 and therefore the reimbursement is $0.00. She noted that Applicant incorrectly appended modifier 59 to CPT codes 22526 and 22527. She stated that based on the NCCI policy manual, modifier 59 "is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters." She noted that,

"documentation must support a different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury . . . not ordinarily encountered or performed on the same day by the same individual."

She noted that from an NCCI perspective, this could not include treatment of contiguous structures of the same organ. She stated that in this case, "all surgical services are being performed on the L4-L5 lumbar spine," and "CPT code 22526 is not being performed at a different site or organ system, separate incision/excision, separate lesion or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual."

In rebuttal, Applicant submitted an affidavit by Alpa Prajapati, CPC. Ms. Prajapati stated that CPT code 62287 was reimbursed at 100% and CPT codes 22526 and 22527 were reimbursed at 50% each. She noted that "the significant procedure consolidation does not apply to the billed CPT codes," as under the FAQs of implementing the 3M EAPG system, "EAPG type in discussion is 28 which is not applicable to the significant procedure consolidation rule." She also stated that "there is no NCCI conflict between 62287, 22526, and 22527," and "NCCI allows those codes to be reimbursed together even without modifier 59." She also noted that modifier 59 was properly used because the operative report showed that surgical services were performed on multiple levels of the lumbar spine, on the L4-L5 and L5-S1 levels via separate incisions. Lastly, she stated that the NCCI edits do not apply to this provider under the EAPG Payment Methodology, as "in this case the provider is a freestanding Ambulatory Surgery Center (ASC), not a hospital-based surgery center." Lastly, she attached a fee audit from the 3M supporting Applicant's billing.

IHC Report

I requested an Independent Health Consultant (IHC) review in this case regarding the fee schedule issue. Ms. Ehrlich, a Certified Professional Medical Auditor submitted a report. Ms. Ehrlich stated that she reviewed both parties' fee coder affidavits, an IHC report submitted from another case by Applicant, as well as the Fee schedule and 3M printout. Ms. Ehrlich stated that "I arrived at the EAPG amount using the DOH rate files available to perform this function manually." She noted that the EAPG computation may be performed manually and the 3M product is not absolutely required to make the necessary calculations. She also stated that applying NCCI edits and CPT guidance in

this case provides more accurate guidance for reimbursement. She noted that "as per the EAPG system, 100% payment will be made for the highest cost APG and 50% discount will then be applied for the remaining procedures."

She cited to the Workers' Compensation EAPG Ambulatory Surgery Fee Schedule FAQs and noted that, contrary to Ms. Prajapati's analysis, NCCI edits are used in calculating reimbursement under the EAPG methodology for ambulatory surgery centers. She noted, however, that Ms. Prajapati was correct that there is no NCCI conflict between CPT 62287, 22526, and 22527, and these codes are allowed to be billed together with no NCCI edit. She stated that modifier 59 is not applicable to these codes and "an add-on code (CPT 22527) does not require modifier 59 since it cannot be billed on its own and must be billed with a primary code." She stated that in this case CPT 22527 is not separately billable since there is no documentation in the operative report supporting the use of this case.

She noted that CPT 22526 is discounted at 50% since this is a separate procedure subject to the multiple procedure reduction rule. She also noted that Ms. Prajapati was incorrect regarding why the consolidation rule does not apply to EAPG 28 because Prajapati's statement failed to demonstrate an understanding of the difference between types versus group. She stated that CPT codes 62287, 22526, and 22527 are assigned final EAPG 28, final EAPG type 2, significant procedure, discounting flag, multiple procedure discounting candidate. She noted that when billed together, they are subject to the multiple procedure reduction rule and consolidation does not apply in this case. Finally, she noted that discounting applied to CPT 22526 and 22527, however documentation does not support billing of CPT 22527. Therefore, she noted that $2605.78 is reimbursable in this case.

In this case, I find the IHC report was persuasive. As described above, the IHC report was detailed, reviewed and evaluated both parties' affidavits, and cited to numerous sources. The IHC report explained that the 3M software, which Applicant relied upon, could be helpful, but manual computation could be performed. The IHC report analyzed the fee coder affidavits. The report referred directly to the medical reports and noted that CPT code 22527 was not supported in this case. The report also noted that in this case discounting applied to CPT 22526.

Therefore, having carefully considered the submissions of the parties, the relevant case law and the arguments of respective counsel, I find that Applicant is awarded **$2605.78.**

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**
	All City Family Healthcare Center	**06/17/19 - 06/17/19**	**$5,211.56**	**Awarded: $2,605.78**
Total			**$5,211.56**	**Awarded: $2,605.78**

B. The insurer shall also compute and pay the applicant interest set forth below. 12/02/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant's award shall bear interest at a rate of two percent per month, calculated on a pro rata basis using a 30-day month from the date payment became overdue to the date of the payment of the award pursuant to 11 NYCRR 65-3.9 (a). The end date for the calculation of the period of interest shall be the date of payment of the claim. General Construction Law § 20 ("The day from which any specified period of time is reckoned shall be excluded in making the reckoning.")

C. Attorney's Fees

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

Respondent shall pay Applicant a separate attorney's fee, in accordance with 11 NYCRR 65-4.6(d). Since the within arbitration request was filed on or after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D).

Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with 11 NYCRR 65-4.6(d).

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

11/18/2020
(Dated)

Samiya Mir

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:
7a5639764cc28dcdf84edbcb06af0825

Electronically Signed

Your name: Samiya Mir
Signed on: 11/18/2020