American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

American Ambulatory Surgery Center DBA Surgery Center of Oradell (Applicant)	AAA Case No.	17-20-1155-8022
	Applicant's File No.	BT19-106974
- and -	Insurer's Claim File No.	1063549-01
	NAIC No.	16616
American Transit Insurance Company (Respondent)		

ARBITRATION AWARD

I, Gregory Watford, 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 (RC)

1. Hearing(s) held on 10/20/2020
   Declared closed by the arbitrator on 10/20/2020

   Jason Behar from The Tadchiev Law Firm, P.C. participated by telephone for the Applicant

   Fotini Lambrianidis from American Transit Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 4,555.44**, 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 dispute arises from the underlying automobile accident of July 15, 2019, in which the Assignor, a 40 year old male, was a driver. As a result of the impact, he complained of injuries to his neck, lower back, right shoulder, and right knee. He was treated and released from local hospital. Thereafter, he sought private medical attention where he was evaluated and diagnosed with cervical radiculopathy. He was recommended for conservative care treatments and referred for diagnostic testing.

   On August 22, 2019, Assignor received a cervical facet injection. In dispute in this case are the facility fees for the injection. Applicant timely submitted the bill to

Respondent for payment in the amount of $4,555.14. Respondent timely denied payment based on the grounds that Assignor's claim must be submitted to the Workers' Compensation Board and Respondent also denied payment based upon the peer review of Dr. Richard Weiss.

The issues to be decided in this case are:

Whether Applicant established entitlement to No-Fault compensation for a cervical facet injection and related services provided to Assignor.

Whether Assignor was working within the scope of his employment when the accident occurred, if not,

Whether Respondent made out a prima facie case of lack of medical necessity and, if so, whether Applicant rebutted it.

Whether Respondent established that Applicant billed in excess of the Fee schedule.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the submissions and documents contained in the American Arbitration Association's ADR Center Electronic Case File (ECF). These submissions constitute the record in this case. This case was decided on the submissions of the parties as contained in the ECF and the oral arguments of the parties' representatives. There were no witnesses.

A claimant's prima facie proof of claim for no-fault benefits must demonstrate that the prescribed claim forms were mailed to and received by the insurer. Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 506, 14 N.Y.S.3d 283, 290 (2015). After reviewing the record and evidence presented, I find that Applicant established a prima facie case of entitlement to reimbursement of its claim. Viviane Etienne Med Care, PC v. Countrywide Ins. Co., *Id*. Once an applicant establishes a prima facie case, the burden then shifts to the insurer to prove its defense. See Citywide Social Work & Psych. Serv. P.L.L.C v. Travelers Indemnity Co., 3 Misc. 3d 608, 2004, NY Slip Op 24034 (Civ. Ct., Kings County 2004).

WCB defense

There are three (3) other linked cases under AAA case # 17-20-1155-8022, 17-20-1155-8029, & 17-19-1150-5162 with the same Assignor but different Applicants which was also heard by this arbitrator on the same date. Both cases raise the same threshold issue that must be decided based upon the same facts. Therefore, I will consider both submissions as they relate to this issue in order to make my decision in this matter.

The issue before this arbitrator is whether there is any potential merit to Respondent's claim that there is a question of fact for consideration by the Workers' Compensation Board (WCB). If there is a question as to whether Assignor was working within the scope of his employment when the accident occurred, the claim should go to the WCB first, for a determination as to that issue. If it is determined the accident did not occur within the scope of the Assignor's employment, and the accident involved a motor vehicle such that no-fault insurance would apply, then it should be decided by a no-fault arbitrator.

Respondent's denial asserted *"Claimant is eligible for Workers' Comp, as Claimant was in the course of employment as a result this claim must be submitted to the employer's Workers Compensation carrier."*

Where the availability of workers compensation hinges upon the resolution of questions of fact or upon mix questions of fact and law, the plaintiff may not choose the courts is the forum for resolution of such questions. The legislature has placed the responsibility for these determinations with the WCB and they are must remain. Arvatz v. Empire Mutual Insurance Company, 171 A.D. 2d 262 (1st Dept. 1991). The board has "primary an exclusive jurisdiction" to resolve the question of coverage and plaintiff has no choice but to litigate the issue before the board. Liss v. Trans Auto System, Inc., 69 N.Y.2d 15. An injured person may not elect between Worker's Compensation benefits and no-fault benefits. Carlo Service Corp. v Rachmani, 64 A.D. 2d 579 (1st Dept. 1978). The WCB has primary jurisdiction to determine factual issues concerning coverage under the Worker's Compensation law. AR Medical Rehabilitation PC v. American Transit InsuranceCompany, 27 Misc. 3d 133 (A), 92 NYS 2d 403 (App. Term 2d, 11th and 13th District2010).

Applicant's counsel provided a copy of a WCB's determination letter dated 10/30/19, which indicated that after their investigation, the Board has no jurisdiction regarding Assignor's claim from the 7/15/19 accident. The WCB determined that Assignor's injury does not meet the qualifying criteria for the WCB to assume jurisdiction over the claim. The Board's letter instructed Assignor to submit a No-Fault claim to an insurance company.

Respondent provided a copy of a Notice of Decision from the WCB which indicated that a hearing was held on 4/7/20 involving Assignor's claim and Judge Barry Hermelee disallowed the claim.

Based upon the foregoing, Respondent's defense that WCB is the proper forum for the instant claim cannot be sustained.

Medical Necessity - Peer Review

A presumption of medical necessity attaches to a timely submitted no fault claim. Elmont Open MRI & Diagnostic Radiology, P.C. v. State Farm Ins. Co., 26 Misc.3d 1211(A), 906 N.Y.S.2d 779 (Table), 2010 N.Y. Slip Op. 50053(U) at 3, 2010 WL

157564 (Dist. Ct. Nassau Co., Fred J. Hirsh, J., Jan. 6, 2010). The No-Fault carrier may rebut the inference of medical necessity by providing proof that the claimed healthcare benefits were not medically necessary. A. Khodadadi Radiology, P.C. v. New York Central Mutual Fire Ins. Co., 16 Misc. 3d 131(A), 841 N.Y.S.2d 824, 2007 N.Y. Slip Op 51342(U) (App Term, 2nd Dept. 2007).

A denial premised on a lack of medical necessity must be supported by competent evidence such as an independent medical examination (IME), a peer review or other proof which sets forth a factual basis and a medical rationale for denying the claim. See, Amaze Med. Supply Inc. v Eagle Ins. Co., 2 Misc. 3d 128[A], 2003 NY Slip Op 51701[U] [N.Y. App Term, 2nd& 11th Jud Dists 2003]; King's Med. Supply Inc. v Country-Wide Ins. Co., 5 Misc. 3d 767, 771 (Civ. Ct Kings Cty 2004).

The 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, Jacob Nir, M.D. v. Allstate Insurance Co., 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005).

A determination of medical necessity must be based on evidence in existence prior to the rendering of the service. Foster Diagnostic Imaging, PC v General Assur Co., 10 Misc. 3d 428 (Civ. Ct. Kings Cty 2005).

Dr. Weiss reviewed documents including the hospital records, initial evaluation reports, medical records, follow-up evaluation reports, and diagnostic test results. He then outlined the treatment of the Assignor. Addressing the CESI in this case, Dr. Weiss opined:

"The causally related medical necessity for the services related to the cervical spine for the purpose of the procedure f or right C2-3 , C3-4 and C4-5 cervical facet joint injection under fluoroscopic needle guidance performed on 9/19/19 has not been established including all associated services and supplies as specifically enumerated below. There were no findings documented to correlate with the diagnosis of cervical spondylosis as per the procedure report. The goal of treatment is to relieve muscle spasm, reduce swelling, decrease pain and increaserange of motion. All of the modalities rendered help to achieve these goals. The necessity for the cervical and lumbar injections, trigger point injections and associated services has not been established. "Nonpharmacologic treatment modalities include acupuncture, osteopathic manual medicine techniques, massage, acupressure, ultrasonography, application of heat or ice, diathermy, transcutaneous electrical nerve stimulation, ethyl chloride Spray and Stretch technique, dry needling, and trigger point injections with local anesthetic, saline, or steroid. The long-term clinical efficacy of various therapies is not clear, because data that incorporate pre- and posttreatment assessments with control groups are not available ." (Am Fam Physician . 2002 Feb 15 ; 65 (4) :653-661.)" Cervical epidural injections f or managing chronic neckpain is one of the commonly performed interventions in the United States. However, the literature supporting cervical epidural

steroids in managing chronic pain problems hasbeen scant and no systematic review dedicated to the evaluation of cervical inter laminar epidurals has been performed in the past. " (Pain Physician 2009 : 12: 1 : 137-157) Based on the review of the clinical evaluation findings, there was no medical necessity for the services outlined."

Every peer review requires individual scrutiny to determine whether the burden should be shifted back to the claimant to submit contrary expert proof. The conclusory opinions of the peer reviewer, standing alone and without support of medical authorities, will not be considered sufficient to establish the absence of medical necessity. (See, Amaze Medical Supply Inc. v. Eagle Ins. Co., 2 Misc.3d 128(A), 784 N.Y.S.2d 918 (Table), 2003 N.Y. Slip Op. 51701(U), 2003 WL 23310886 (N.Y. App. Term 2nd & 11th Dists. Dec. 24, 2003).

I find that the peer review of Dr. Weiss is insufficient to support its initial burden to demonstrate a lack of medical necessity for the cervical facet injections. He failed to set forth the generally accepted medical standard for prescribing or not prescribing the injections in question. Although he stated that "There were no findings documented to correlate with the diagnosis of cervical spondylosis as per the procedure report" he failed to cite to any medical authority to support the statement. Moreover, I find his statement conclusory because he failed to meaningfully reference Assignor's injuries and symptoms to demonstrate that the prescribing physician deviated from the generally accepted medical standard for performing the procedure.

In light of the foregoing, I find that the peer reviewer's opinion is not based on a sufficient factual basis specific to this Assignor, results in a flawed medical rationale, does not provide a standard of care for the Assignor's injuries, and does not meet Respondent's burden of proof. Based upon the foregoing I find that Respondent has not sufficiently established a prima facie defense that the cervical facet injection prescribed in this case were not medically necessary.

There is no need to consider Applicant's rebuttal evidence, or lack thereof, since Applicant's claims arrived at this arbitration carrying a presumption of medical necessity, which has not been rebutted by Respondent. See, Millennium Radiology, P.C. v. New York Central Mutual Fire Ins. Co., 23 Misc.3d 1121(A), 886 N.Y.S.2d 71 (Table), 2009 N.Y. Slip Op. 50877(U), 2009 WL 1261666 (Civ. Ct. Richmond Co., Katherine A. Levine, J., Apr. 30, 2009). Consequently, the burden does not shift to Applicant to rebut Respondent's proof.

Accordingly, Applicant is entitled to be reimbursed consistent with the fee schedule.

Fee Schedule

After the effective date of the Fourth Amendment to 11 NYCRR 65-3, an insurer may raise a defense that a health service provider failed to adhere to fee schedule ground rules despite it not being raised in a denial. USAA General Indemnity Co. v. New York Chiropractic & Physical Therapy, PLLC, 60 Misc.3d 254 (Civ. Ct. Richmond Co., Lisa Grey, J., May 1, 2018).

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. Continental Medical PC v. Travelers Indemnity Co ., 11 Misc.3d 145A, 819 N.Y.S.2d 847, (N.Y. App. Term, 1st Dep.t, 2006); Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 13 Misc.3d 172, 822 N.Y.S.2d 378, (Civil Ct, Kings Co. 2006).

When the issue in contention involves the appropriateness of a billing adjustment based on the fee schedule, Respondent must first demonstrate that it has timely and credibly established the basis for its denial(s), before the burden of proof shifts to the Applicant to establish that Respondent's adjustment was contrary to No-Fault regulations and/or the applicable fee schedule. Applicant must then establish a prima facie case of entitlement to additional reimbursement by demonstrating credible evidence that the adjusted rate of reimbursement was incorrect. (See, Westchester Medical Center v. Nationwide Mut. Ins. Co., 78 A.D.3d 1168, 911 N.Y.S.2d 907 (2d Dept. 2010). As of April 1, 2013, the effective date of the Fourth Amendment to 11 NYCRR 65-3, Respondent is only required to reimburse Applicant in accordance with the applicable fee schedule.

I take judicial notice of the Worker's Compensation fee schedule. See Kingsbrook Jewish Medical Center the Allstate Insurance Company, 61 AD 3d 13 (N.Y. App. Div. 2nd Dept. 2009); LVOV Acupuncture PC v. Geico Insurance Company, 32 Misc. 3d 144 (A) (N.Y. App. Term 2nd, 11th and 13th Jud. Dists. 2011). Natural Acupuncture Health PC v. Praetorian Insurance Company, 30 Misc. 3d 132 (A), 2011 N Y slip op 50040 (U), (N.Y. App. Term 1st Dept. 2011).

The services in this case were provided in Saddle River NJ in the NJ North section of the NJ Fee schedule. Applicant billed $1,518.48 under each of the CPT codes 64490, 64491 & 64492.

The newly-revised 11 NYCRR § 68.6(b) - which pertains to all services performed on and after January 23, 2018 - explicitly 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.

It must also be noted here that as of October 1, 2015, the New York State Workers Compensation Board transitioned from a Products of Ambulatory Surgery ("PAS") methodology surgery fee schedule to an EAPG methodology. 11 NYCRR 68.6 states that when a procedure is performed at an ambulatory surgery center that the correct

reimbursement will be either the amount as prescribed by the EAPG or the New Jersey Fee Schedule, whichever is the lesser.

Respondent did not provide a coder affidavit to establish the EAPG rate for NYS.

The prevailing rate under the N.J. Fee schedule requires a reduction in the amounts billed by Applicant.

Section N.J.A.C. 11:3-29.4(f) of the New Jersey Fee Schedule which sets forth the application of the rules for multiple and bilateral surgical procedures provides:

"Except as specifically stated to the contrary, the following shall apply to physician charges for multiple and bilateral surgeries (CPT 10000 through 69999), co-surgeries and assistant surgeons:

1. For multiple surgeries, rank the surgical procedures in descending order by the fee amount, using the fee schedule or UCR amount, as appropriate. The highest valued procedure is reimbursed at 100 percent of the eligible charge. Additional procedures are reported with the modifier "-51" and are reimbursed at 50 percent of the eligible charge. If any of the multiple surgeries are bilateral surgeries using the modifier "-50," consider the bilateral procedure at 150 percent as one payment amount, rank this with the remaining procedures, and apply the appropriate multiple surgery reductions."

Under the fee schedule Applicant is entitled to $1,012.32 for CPT code 64490, and $177.98 for CPT codes 64491 ($355.95) & 94492 ($355.95) based upon the multiple procedure rules ($355.95 x.50% = $177.98 for each code). Based upon the foregoing the amount billed by Applicant is in excess of the amount allowed under the N.J. Fee schedule.

11 NYCRR § 65-4.5(o)(1) provides that an arbitrator shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to the legal rules of evidence shall not be necessary. The arbitrator may question or examine any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department regulations.

Although Respondent did not provide any support for a fee schedule defense, I find under the NJ Fee schedule, Applicant is entitled to a total of $1,368.27.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot, without merit, and/or waived insofar as not raised at the time of the hearing.

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**
	American Ambulatory Surgery Center DBA Surgery Center of Oradell	**09/19/19 - 09/19/19**	**$4,555.44**	**Awarded: $1,368.27**
Total			**$4,555.44**	**Awarded: $1,368.27**

B. The insurer shall also compute and pay the applicant interest set forth below. 02/05/2020 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. 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.")

   Where a claim is timely denied, interest shall begin to accrue as of the date arbitration is requested by the claimant unless arbitration is commenced within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the 30th day after proof of claim was received by the insurer. 11 NYCRR 65-4.5(s)(3), 65-3.9(c); Canarsie

Medical Health, P.C. v. National Grange Mut. Ins. Co., 21 Misc.3d 791, 797 (Sup. Ct. New York Co. 2008) ("The regulation provides that where the insurer timely denies, then the applicant is to seek redress within 30 days, after which interest will accrue.")

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) subject to a maximum fee of $1,360.

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, Gregory Watford, 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)

Gregory Watford

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:
9f716ab62f08f48136ddd3f9944803aa

Electronically Signed

Your name: Gregory Watford
Signed on: 11/18/2020