

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Priority Health & Wellness of Montvale, LLC (Applicant)	AAA Case No.	17-19-1116-1340
- and -	Applicant's File No.	2203332
	Insurer's Claim File No.	0502281082 2PU
Allstate Insurance Company (Respondent)	NAIC No.	19232

**ARBITRATION AWARD**

I, Charles Blattberg, 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: Eligible injured person

1. Hearing(s) held on 08/21/2020  
Declared closed by the arbitrator on 08/24/2020

Catherine Ramsawak, Esq. from Israel, Israel & Purdy, LLP (Great Neck) participated by telephone for the Applicant

James McNamara, Esq. from Law Offices Of Karen L. Lawrence participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,833.76**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant reduced the total amount in dispute to \$985.43 pursuant to fee schedule.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The claimant was the 31 year-old male restrained driver of a motor vehicle that was involved in an accident on 5/15/18. Following the accident the claimant suffered injuries which resulted in the claimant seeking treatment. At issue are chiropractic and acupuncture services provided by Applicant 10/2/18-11/26/18.

#### 4. Findings, Conclusions, and Basis Therefor

Based on a review of the documentary evidence, this claim is decided as follows:

An applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case for reimbursement.

The claimant was the 31 year-old male restrained driver of a motor vehicle that was involved in an accident on 5/15/18. The claimant reportedly injured his neck, upper back, lower back, and right knee. There was no reported loss of consciousness. There were no reported lacerations or fractures. There was no reported emergency treatment sought or received. On 5/17/18 the claimant presented to Renato Cappello, D.C. of Priority Health & Wellness of Montvale, LLC (Applicant). Dr. Cappello prescribed MRIs (cervical spine, lumbar spine, and right knee) and the claimant was initiated on chiropractic treatment. On 5/17/18 the claimant presented to an acupuncturist of Applicant's office with a tooth-marked purple tongue with a thin white coating and a weak superficial pulse. The claimant was initiated on acupuncture care. The 7/6/18 cervical spine MRI interpreted by Steve B. Losik, M.D. produced an impression of C3-4 disc bulge with compression of anterior thecal sac and partial effacement of anterior subarachnoid space and posterior central C4-5 disc herniation with compression of ventral thecal sac and partial effacement of ventral subarachnoid space. The 7/6/18 lumbar spine MRI interpreted by Steve B. Losik, M.D. produced an impression of L4-5 disc bulge with encroachment on the neural foramina, L5-S1 disc bulge with encroachment on the neural foramina, and straightening of lumbar lordosis which may represent pain or muscle spasm. The 7/6/18 right knee MRI interpreted by Steve B. Losik, M.D. produced an impression of the ACL appears thickened and heterogeneous and indistinct consistent with a high grade partial tear in an appropriate clinical setting, 6 mm erosive/osteochondral lesion on intercondylar notch of the femur, and the extensor mechanism, PCL, the menisci and the collateral ligaments are intact. On 9/11/18 the claimant was required to present to Ji Hoon Kim, D.C., L.Ac. for an independent chiropractic/acupuncture examination (IME) that was purportedly negative and Respondent determined "As per the findings of the physical examination conducted by Dr. JI KIM on 9/11/18, all chiropractic, acupuncture and massage therapy benefits were denied effective 10/4/18." At issue are chiropractic and acupuncture services provided by Applicant 10/2/18-11/26/18.

As an initial matter the fee schedule must be addressed. It is Respondent's burden to come forward with competent evidentiary proof to support its fee schedule defenses. See *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).

Ground Rule 3 of the Physical Medicine Section of the Chiropractic Fee Schedule, *Multiple Physical Medicine Procedures and Modalities*, which applies to chiropractors, and is also commonly referred to as the "8-Unit Rule", reads: "When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 8.0 RVUs or the amount billed, whichever is less. The following codes represent the physical medicine procedures and modalities subject to this rule: 97010, 97012, 97014, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97530, 98940, 98941, 98942."

Additionally, these services are governed by a conversion rate of 8.45 for medical physicians, 7.70 for physical and occupational therapists who are self-employed, and 5.78 for chiropractors and licensed acupuncturists.

The services in dispute were provided to a New York resident and 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 did not provide a fee coder affidavit or audit. However, Respondent argued at the hearing that based on a clear reading of the applicable codes and mathematical calculations that Applicant billed in excess of the applicable fee schedules.

In New York, the maximum allowable reimbursement for codes subject to the 8-unit rule is \$46.24 (5.78 RVUs x 8) for chiropractors, which was reimbursed for date of service 10/2/18. Applicant argues that code G0283 is not subject to the 8-unit rule and additional reimbursement in the amount of \$20.00 per date of service is warranted. Code G0283, a New Jersey code, described as "Electro muscle Stimulation" is not listed in the NYS Worker's Compensation Fee Schedule. However, codes can be cross walked. Arbitrator Meryem Toksoy did a thorough and well-reasoned analysis of cross walking codes in Advanced Spinal Care Rehabilitation PA and Geico Insurance Company, AAA Case No.: 17-18-1106-2153, (9/24/2019), which states in pertinent part:

*"ORDER OF OPERATIONS: NEW YORK:*

*STEP 1: CROSSWALKING. CPT 27198 is not listed in the Surgery section of the Medical Fee Schedule. Determine whether to crosswalk the code to CPT 27194, which is listed.*

....

*REGARDING STEP 1:*

*WHETHER CPT 27198 CAN BE CROSSWALKED TO CPT 27194:*

*To the extent that a claim is subject to review based on the conditions set forth in the 33rd Amendment, I find that it is both appropriate - and necessary - to crosswalk a code.*

*The 33rd Amendment to 11 NYCRR 68 [Regulation 83] was introduced as a cost containment measure. The specific reasoning for its enactment can be found in the New York State Register. In the Notice of Proposed Rule Making, dated 09-28-16, the Department of Financial Services offered the following explanation:*

*There has been no uniform interpretation of the prevailing fees outside the State. As a result, no-fault claimants are being referred to certain health care providers outside New York, usually in New Jersey, who take advantage of the absence of specific fee schedules and submit excessive charges under exaggerated claims, well above the corresponding New York State fee schedules applicable to those health care services rendered. Since basic personal injury protection coverage under no-fault is only \$50,000, the higher the bills, the sooner the injured person will find coverage exhausted. This results in no-fault benefits available to injured persons being depleted more quickly, to their detriment.*

*Representatives of both the insurance industry and the medical profession have conveyed to the Department that amending the current regulation is necessary in order to close these loopholes that have resulted in increased no-fault claim bills. In addition, numerous arbitrators that serve on the Department's no-fault arbitration panel have indicated that this issue has generated a significant number of disputes due to the significant disparity between the excessive fees being charged*

*by out of state health care providers and those permitted under the current rule. By setting a maximum fee that out-of-state health care providers may receive as reimbursement for no-fault-related health services, this amendment should lead to reduced arbitration and litigation costs for insurers and self-insurers, which are typically passed to consumers in the form of higher premiums, as well as help to stem the rapid depletion of no-fault benefits available to eligible injured persons.*

*On 05-24-17, a Notice of Revised Rule Making for the 33rd Amendment to 11 NYCRR 68 [Regulation 83] was published in the New York State Register, with the analysis being substantially the same. The provision took effect on 01-23-18 and guides how this case is decided*

....

*In terms of regulations, the New Jersey Administrative Code permits crosswalking. At the beginning of NJAC §11:3-29.4(e), it states:*

*[T]he 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.*

*For New York and health services not covered in the adopted fee schedules, 11 NYCRR §68.5 governs. It accounts for the following two scenarios:*

*If a professional health service is performed which is reimbursable under section 5102(a)(1) of the Insurance Law, but is not set forth in fee schedules established by the superintendent, and:*

*(a) if the superintendent has adopted or established a fee schedule applicable to the provider, then the provider shall establish a fee or unit value consistent with other fees or unit values for comparable procedures shown in such schedule, subject to review by the insurer; or*

*(b) if the superintendent has not adopted or established a fee schedule applicable to the provider, then the permissible charge for such service shall be the prevailing fee in the geographic location of the provider subject to review by the insurer for consistency with charges permissible for similar procedures under schedules already adopted or established by the superintendent.*

....

*This leads me to the 33rd Amendment. This provision was enacted as a cost containment measure. For the purpose of realizing this intent, the provision mandates a comparison. It requires balancing the amount that was billed against the amounts which are allowed for New York and the state where the service was performed.*

*If a crosswalk is not allowed, the 33rd Amendment turns from a scale that is intended to balance and compare into a scale that has a thumb placed on it.*

*Taking such an approach would mean that a provider's entitlement to a claimed service is entirely extinguished. In turn, this may also impact the reimbursement rate for other services that are listed on the bill (e.g., via the Multiple Procedure Reduction rule).*

*I do not consider this to be a just way of evaluating a claim."*

I find that the service billed under code G0283, which is not listed in the NY fee schedule should be cross walked to code 97014, described as "Application of a modality to 1 or more areas; electrical stimulation (unattended)." The services were performed by a chiropractor. Therefore pursuant to, 11 NYCRR §68.5(a) as "the superintendent has adopted or established a fee schedule applicable to the provider, then the provider shall establish a fee or unit value consistent with other fees or unit values for comparable procedures shown in such schedule, subject to review by the insurer." In this case the code descriptions for Code G0283 and CPT code 97014 are comparable and code 97014 should be utilized in determining the NY fee schedule for the services billed, which has a RVU of 2.66 and is subject to Ground Rule 3 of the Chiropractic Fee Schedule (8-unit rule). I find that Respondent paid the claim for date of service from 10/2/18 in accordance with the fee schedule. Additionally, if the chiropractic services performed 10/4/18-11/26/18 are found to be medically necessary Applicant would be entitled to \$589.36 (without separate reimbursement of code G0283). A discussion of medical necessity follows.

The burden has shifted to the Respondent as they have raised a medical necessity defense. In order 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. 20140). 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). As a general rule, reliance on rebuttal documentation will be weighed in light of the documentary proofs and the arguments presented at the arbitration. Moreover, the case law is clear that a provider must rebut the conclusions and determinations of the IME/peer doctor with his own facts. *Park Slope Medical and Surgical Supply, Inc. v. Travelers*, 37 Misc.3d 19 (2012).

An IME report asserting that no further treatment is not medically necessary must be supported by a sufficiently detailed factual basis and medical rationale, which includes mention of the applicable generally accepted medical/professional standards. *Carle*

*Place Chiropractic v. New York Central Mutual Fire Ins. Co.*, 19 Misc.3d 1139(A), 866 N.Y.S.2d 90 (Table), 2008 N.Y. Slip Op. 51065(U), 2008 WL 2228633 (Dist. Ct. Nassau Co., Andrew M. Engle, J., May 29, 2008).

Respondent timely denied the 10/4/18-11/26/18 chiropractic services and 10/16/18-10/30/18 acupuncture services at issue based on the 9/11/18 independent chiropractic/acupuncture examination (IME) conducted by Ji Hoon Kim, D.C., L.Ac. After reviewing the claimant's history, treatment, and medical records, Dr. Kim conducts what appears to be a thorough examination. Dr. Kim documents the claimant's then current complaints as pain in the neck, mid-back, lower back and right knee; as well as headaches. Examination of the cervical spine revealed no tenderness upon palpation. There were no spasms. There was no evidence of disturbed alignment due to injury. Neurological examination of the upper extremities demonstrated normal muscle strength (5/5) in all major muscle groups. Sensory responses were intact throughout the upper extremities. Deep tendon reflexes of the biceps, triceps and brachioradialis were symmetrical and normal bilaterally. Cervical Compression test was negative. Cervical distraction test was negative. Cervical range of motion was within normal limits (quantified). Examination of the thoracic spine revealed no tenderness upon palpation. There were no paraspinal spasms. There was no evidence of disturbed alignment due to injury. Examination of the lumbar spine revealed no tenderness upon palpation. There were no paraspinal spasms. There was no evidence of disturbed alignment due to injury. Neurological examination of the lower extremities demonstrated normal muscle strength (5/5) in all major muscle groups. Sensory responses were intact throughout the lower extremities. Patellar and Achilles reflexes were symmetrical and normal bilaterally. Seated straight leg raising test was negative. Kemps test was negative. Lumbar range of motion was within normal limits (quantified). Examination of the right knee revealed no tenderness upon palpation. There was no swelling. Range of motion was within normal limits (quantified). Acupuncture examination revealed "TONGUE: Tongue was normal with no evidence of traumatic injury. PULSE: Pulse was normal with no evidence of traumatic injury. COMPLEXION AND BREATHING: Complexion and breathing pattern was normal. HEADACHES: None." Dr. Kim's diagnosis was cervical spine sprain/strain resolved, thoracic spine sprain/strain resolved, lumbar spine sprain/strain resolved, and Qi and Blood stagnation in the head, cervical spine, thoracic spine, lumbar spine and right knee resolved. Dr. Kim concluded "objectively, the chiropractic examination demonstrated no positive findings. Further chiropractic treatment is not necessary. From an acupuncturist's point of view, there was no evidence of Qi and Blood stagnation in the head, cervical spine, thoracic spine, lumbar spine and right knee. Further acupuncture treatment is not necessary. There is no need for diagnostic testing, household help, special transportation or medical supplies. There is no need for massage therapy."

If 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, *West Tremont Medical Diagnostic P.C., v. Geico*, 13 Misc.3d 131 (A), 824 NYS 2d 759 (App. Term 2d & 11th Dists, 2006).

On 10/25/18 Dr. Cappello conducted a follow-up examination (most contemporaneous post IME in evidence). The claimant presented with complaints of neck pain rated 4/10,

upper back pain rated 4/10, lower back pain rated 4/10, and right knee pain rated 3/10. Cervical range of motion was restricted in all planes (quantified). Lumbar range of motion was restricted in all planes (quantified). Deep tendon reflexes were diminished in the left (biceps, triceps, and brachioradialis). Positive orthopedic tests were Rotary Compression, Hyperextension Compression, Soto Hall, Lasegue's, Braggard's, Well Leg Raise, Kemp's, Ely's, Yeoman's, McMurray's (right knee) and Valgus/Varus Stress (right knee).

On 10/30/18 Applicant conducted an acupuncture reevaluation (most contemporaneous post IME in evidence). The claimant presented with complaints of neck pain rated 6/10, lower back pain rated 5/10, and right knee pain rated 6/10. Examination revealed a normal shaped pale purple tongue with a thin white coating and a wiry shallow pulse. The claimant was diagnosed with Bi Syndrome and recommended for continued acupuncture twice per week for 5 weeks.

I find that the chiropractic and acupuncture records relied on by Applicant show consistent complaints of pain with positive findings thereby warranting additional treatment. I am persuaded that the contemporaneous chiropractic and acupuncture records indicate the claimant was benefiting from further treatment. I find Applicant has successfully rebutted the findings and recommendations of Dr. Kim's IME report and established the need for the services at issue that were performed beyond the 10/4/18 cut-off date.

Accordingly, Applicant is awarded \$725.43.

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	Amount Amended	Status
	Priority Health & Wellness of Montvale, LLC	10/02/18 - 10/25/18	\$713.76	\$368.54	Awarded: \$248.54
	Priority Health & Wellness of Montvale, LLC	10/16/18 - 10/30/18	\$250.00	\$135.87	Awarded: \$135.87
	Priority Health & Wellness of Montvale, LLC	10/30/18 - 11/26/18	\$870.00	\$481.02	Awarded: \$341.02
Total			\$1,833.76		Awarded: \$725.43

B. The insurer shall also compute and pay the applicant interest set forth below. 01/08/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from 1/8/19 (the date that arbitration was requested) until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty day month.

C. Attorney's Fees

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

Pursuant to 11 NYCRR §65-4.6 (d), ". . . the attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon for each applicant for arbitration or court proceeding, 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, Charles Blattberg, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

11/19/2020  
(Dated)

Charles Blattberg

#### **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:**  
d108a2ff074a6853719e20a8a60a1e8e

### **Electronically Signed**

Your name: Charles Blattberg  
Signed on: 11/19/2020