American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Suarez Medical PLLC (Applicant)	AAA Case No.	17-19-1124-8683
	Applicant's File No.	AF19-103209
- and -	Insurer's Claim File No.	0509572060101049
	NAIC No.	22055
Geico Insurance Company (Respondent)		

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 10/16/2020
   Declared closed by the arbitrator on 10/20/2020

   Cliff Ryan, Esq. from Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara, Wolf & Carone LLP participated by telephone for the Applicant

   Nicole Jeffares from Geico Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 703.49**, 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 claimant was the 55 year-old male unrestrained front seat passenger of a motor vehicle that was involved in an accident on 8/3/18. Following the accident the claimant suffered injuries which resulted in the claimant seeking treatment. At issue is range of motion (ROM) testing and physical performance (NIOSH) testing/Activity Limitation Measurement and Training Report performed by Applicant on 1/16/19.

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 55 year-old male unrestrained front seat passenger of a motor vehicle that was involved in an accident on 8/3/18. The claimant reportedly injured his neck, bilateral shoulders, mid back, low back and bilateral knees. There was no reported loss of consciousness. There were no reported lacerations or fractures. There was no reported emergency treatment sought or received. On 8/8/18 the claimant presented to Stillwell Chiropractic, P.C. and was initiated on chiropractic treatment. On 8/9/18 the claimant presented to Joel Dougherty, L.Ac. of Bliss Acupuncture, P.C. and was initiated on acupuncture and cupping. On 8/23/18 the claimant presented to Alford Alexander Smith, M.D. of Metro Pain Specialists, P.C. and was recommended for physical therapy, prescribed MRIs (cervical spine, lumbar spine, bilateral shoulders, and bilateral knees), prescribed durable medical equipment (consisting of a bed board, thermophore, EMS unit with accessories, water circulating pump, cervical traction unit with pump, cervical pillow, dry pressure mattress, whirlpool, cervical collar, lumbar cushion, and infrared lamp), and prescribed medications (Flexeril, Celecoxib, and Diclofenac 3% gel). On 8/28/18 the claimant underwent cervical plexus (upper) and lumbosacral plexus (lower) pf-NCS testing ordered by Dr. Smith and conducted by Ian Lam, D.C. On 8/28/18 the claimant underwent range of motion and manual muscle testing (ROM/MMT) conducted by Significant Care PT, P.C. On 9/8/18 the claimant underwent a right knee MRI and a right shoulder MRI. On 9/11/18 the claimant underwent physical performance (NIOSH) testing. On 9/20/18 Opeoluwa Oluwabusuyi Eleyinafe, M.D. conducted an examination preliminary to upper extremities and lower extremities EMG/NCV performed the same day that suggested evidence consistent with bilateral median sensorimotor nerves, axonal and demyelinating, peripheral neuropathy of the upper extremities (carpal tunnel syndrome), bilateral lower extremity demyelinating peripheral neuropathy, right peroneal motor nerve axonal peripheral neuropathy, and left C8-T1 cervical radiculopathy and bilateral S1 radiculopathy. On 10/9/18 Dr. Smith prescribed Percocet 5/325 and Diclofenac 3% gel. On 10/10/18 Richard E. Pearl, M.D. performed right shoulder arthroscopy and prescribed the use of a CPM, CTU, and shoulder immobilizer. On 12/6/18 the claimant underwent ROM/MMT. On 1/16/19 Suarez Medical, PLLC (Applicant) conducted ROM testing and physical performance (NIOSH) testing/Activity Limitation Measurement and Training Report; which are at issue here.

Range of motion testing

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).

Respondent timely denied the 1/16/19 ROM testing based on the 3/12/19 peer review by Harry E. Jackson, M.D. After reviewing the claimant's history, treatment, and medical records, Dr. Jackson opines "range of motion testing should be part of a normal physical exam and computerized range of motion testing is redundant and unnecessary. Additionally, the validity and reliability of such testing has been questioned and this type of testing depends on response from the patient, which may not be reliable, and it has not been clinically tested as to its efficacy. Routine computerized ROM measurements in soft tissue sprains/strains and contusions are not necessary. There is no evidence in the medical literature to support the use of computerized range of motion testing after injury such as a motor vehicle accident. According to ODG Treatment Integrated Treatment/Disability Duration Guidelines, Neck and Upper Back (acute and chronic), updated 11/18/2014, the recommendation for the physical examination include "Perform a comprehensive examination of the neck and upper extremities including attention to flexibility, strength, and range-of-motion of the neck." As per ODG Treatment Integrated Treatment/Disability Duration Guidelines, Low Back - Lumbar and Thoracic (acute and chronic), updated 04/15/2013, "The relation between lumbar range of motion measures and functional ability is weak or nonexistent"." Dr. Jackson continues "range of motion should be and typically is a part of a standard clinical examination status post trauma. Formal ROM testing does not provide useful clinical information that cannot be obtained by standard clinical examination in this clinical setting. There was no need to unbundle this service and provide it separately. Thus, providing this separately is not consistent with current medical necessity guidelines, which have three basic criteria: a) in accordance with generally accepted standards of medical practice; b) clinically appropriate in terms of type, frequency, extent, site, and duration; and c) not primarily for the convenience of the patient, physician, or other health care provider (American Medical Association, January 14, 2011, "Statement of the American Medical Association to the Institute of Medicine's Committee on Determination of Essential Health Benefits'). According to "Integrated treatment/Disability Duration Guidelines", Range of motion testing was "Not recommended as a primary criteria, but should be a part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional ability is weak or nonexistent. This has implications for clinical practice as it relates to disability determination for patients with chronic low back pain, and perhaps for the current impairment guidelines of the American Medical Association." (Parks, 2003)

(Airaksinen, 2006)." Dr. Jackson concludes "therefore, range of motion is considered part of the routine clinical examination and unbundling this procedure is inconsistent with standard medical practice. In summary, for the reasons noted above, providing the range of motion separately from the routine clinical examination was not medically necessary in this case."

Applicant submitted a 7/24/20 peer rebuttal by David Suarez, D.O. After reviewing the claimant's history, treatment, and medical records, Dr. Suarez asserts "it should be noted that, as per What Is Range of Motion (ROM)? - Definition, Types, Testing & Exercises: Range of Motion is the measurement of movement around a specific joint or body part. In order for a joint to have full range of motion, it must have good flexibility. Each joint has its own level of flexibility, expressed in degrees. Flexibility is the range of motion around a joint, and can refer to ligaments, tendons, muscles, bones, and joints. If a joint has good range of motion, then it would be able to move in all planes and directions permitted to that joint. Although flexibility is the most neglected fitness component, it is important for general health, injury prevention, and even sports performance. Factors that may contribute to a lack in the range of motion could be pain, swelling, and stiffness in the joints-side effects common in arthritis, rheumatoid arthritis, and osteoarthritis. Injuries can have lasting effects on how freely a joint moves. Other factors that can determine one's flexibility are joint structure, muscles, tendons, ligaments, fat tissue, body temperature, activity level, gender, age, and genetics" [*Citation omitted*]. "As per Range of Motion: What You Need to Know: After suffering from an orthopedic injury, you'll likely be in some pain. However, a lack of joint mobility is the true indicator of an injury's severity. Without the normal range of motion, the affected joint is still injured. The joint's range of motion is the distance that the joint can extend. Without any injury, the joint should fully extend to its normal length. However, during times of injury, joints are generally limited to a smaller range of motion. The range of motion applies to both the joint's movement and the direction in which it can move. At first, a decreased range of motion may appear to be standard soreness, but with time, could grow worse. Like other similar exercises, having the proper range of motion can carry numerous benefits. Aside from being able to properly move, these are some of the most important benefits: Blood Flow; Muscle Strength; Heightened Flexibility; Decreased Pain; Stronger Performance; Reduced Stiffness and Lower Potential for Injury" [*Citation omitted*]. Dr. Suarez continues "as per an article of BMC-Part of Springer Nature: A technical support tool for joint range of motion determination in functional diagnostics - an inter-rater study: Background: The examination of joint range of motion (ROM) is part of musculo-skeletal functional diagnostics, used, for example, in occupational examinations. Various examination methodologies exist that have been optimized for occupational medical practice, which means they were reduced to the most necessary and feasible measures and examinations for efficiency and usability reasons. Because of time constraints in medical examinations in occupational settings, visual inspection is commonly used to quantify joint ROM. To support medical examiners, an inertial sensor-based measurement system (CUELA) was adapted for joint ROM examination in these settings. The objective of the present study was to evaluate the measurement tool in functional diagnostics under conditions close to clinical practice" [*Citation omitted*]. Dr. Suarez concludes "the requested Range of Motion testing was not only medically necessary but the standard of care."

I am faced with conflicting opinions concerning the medical necessity for the disputed testing and treatment herein. There are no legal issues to resolve. This dispute involves solely an issue of fact, that is, whether or not the ROM testing was medically necessary. Resolution of that fact is determined by which opinion is accepted by the trier of fact. I have carefully studied the reports, documents and opinions for each side. I find that Dr. Jackson's peer review failed to meet Respondent's burden of proof. Dr. Jackson failed to set forth a specific standard of care and the authority he cited failed to establish that ROM testing lacked medical necessity. In addition I find the peer rebuttal by Dr. Suarez persuasive which leads me to conclude that Applicant has aptly rebutted the peer review and is entitled to reimbursement in accordance with the fee schedule for the ROM studies. Applicant's bill indicates that ROM of the cervical spine, lumbar spine, thoracic spine, unspecified knee and bilateral shoulders was performed. The description of CPT code 95851 states: "Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)." ROM is reported once per extremity or trunk section, therefore, Applicant is awarded $274.26 for six units (3 extremities plus 3 trunk sections) and not the eleven units billed.

Activity Limitation Measurements

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). An insurance carrier's timely asserted defense that the bills submitted were not properly no-fault rated or that the fees charged were in excess of the Workers' Compensation Fee Schedule is sufficient, if proven, to justify a reduction in payment or denial of claim. *New York Hosp. Med. Ctr. Of Queens v. Country-Wide Insurance Company*, 295 A.D.2d 583, 744 N.Y.S.2d 201 (2nd Dept. 2002); *East Coast Acupuncture, P.C. v. New York Central Mutual Insurance*, 18 Misc.3d 139(A), 2008 N.Y. Slip Op. 50344(U) (App. Term 2nd and 11th Jud. Dists. 2008); *A.B. Medical Services, PLLC v. American Transit Insurance Company*, 15 Misc.3d 132(A), 2007 N.Y. Slip Op. 50680(U) (App. Term 2nd and 11th Jud. Dists. 2007).

An insurer may pursue a defense that fees were excessive where such defense was raised in timely denials. See, *Great Wall Acupuncture, PC v. Geico Insurance Company*, 25 Misc. 3d 137 (A), 2009 (App Term second, 11th and 13th Dists. 2009). The insurer has the burden of coming forward with competent evidentiary proof to support its fee schedule reduction or denial. See, e.g., *Roberts Physical Therapy, P.C. v. State Farm Mutual Automobile Insurance Company*, 13 Misc.3d 172, 3006 N.Y. Slip Op. 26240 (N.Y. Civ. Ct. Kings Co. 2006). In the absence of such proof, a defense of noncompliance with the appropriate fee schedule cannot be sustained. *Continental Medical, P.C. v. Travelers Indemnity Company*, 11Misc,3d 145(A), 2006 N.Y. Slip Op. 50841(U) (App. Term 1st Dept. 2006).

Applicant billed $475.00 for the 1/16/19 Activity Limitation Measurements using a "by report" code (CPT code 97799) which Respondent changed to CPT code 97750 (Physical Performance Testing) and paid in the amount of $274.32. Respondent's timely denial states "[b]ased on the information submitted, the procedure code has been changed to more accurately reflect the services rendered." Physical Performance Testing (code 97750) is a time-based service. Reimbursement is calculated in per 15 minute

intervals. Respondent offered no evidence to explain why CPT code 97750 most closely described the services at issue or how they calculated the amount of time for which Applicant should be reimbursed. Further, Respondent should have requested additional verification of this claim in order to establish the time spent in rendering this service. See, *Gaba Medical, P.C. v. Progressive Specialty Ins. Co.*, 36 Misc.3d 139(A), 957 N.Y.S.2d 264 (Table), 2012 N.Y. Slip Op. 51448(U), 2012 WL 3139780 (App. Term 2d, 11th & 13th Dists. July 25, 2012). Applicant is entitled to additional reimbursement of $200.68.

Accordingly, Applicant is awarded $474.94.

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**
	Suarez Medical PLLC	**01/16/19 - 01/16/19**	**$502.81**	**Awarded: $274.26**
	Suarez Medical PLLC	**01/16/19 - 01/16/19**	**$200.68**	**Awarded: $200.68**
Total			**$703.49**	**Awarded: $474.94**

B. The insurer shall also compute and pay the applicant interest set forth below. 04/05/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from 4/5/19 (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.

12/01/2020
(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:
656de9d561659c77dcf775a64938303d

Electronically Signed

Your name: Charles Blattberg
Signed on: 12/01/2020