

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Phoenix Medical Services P.C. DBA
Rockville Centre Pain Management &
Rehabilitation
(Applicant)

- and -

Allstate Insurance Company
(Respondent)

AAA Case No.	17-19-1132-5350
Applicant's File No.	2229305
Insurer's Claim File No.	05060916102KH
NAIC No.	19232

ARBITRATION AWARD

I, John Langell, 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 05/26/2020, 01/26/2021, 02/09/2021
Declared closed by the arbitrator on 02/09/2021

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

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

2. The amount claimed in the Arbitration Request, **\$ 40,654.34**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount in controversy has been amended to 17,685.98 to conform to the Applicant's fee schedule evidence.

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

3. Summary of Issues in Dispute

The Assignor is a then 32 year old female who was injured in an automobile accident on 6/16/18. Assignor underwent separate cervical and lumbar discectomy procedures, as

well as several office visits, from 9/27/18 to 10/15/18. Reimbursement for one office visit was denied based on the 120 day rule. Reimbursement for another office visit was never paid or denied based on a claim of outstanding verification. Reimbursement for the two discectomy procedures was denied based on a peer review. Fee schedule issues have also been raised. The issues for resolution at this hearing include whether one of Applicant's bills was appropriately pended for payment or denial, whether the denials asserted with respect to the Applicant's other bills may be sustained, and whether the Applicant's bills were in accordance with the applicable fee schedule.

4. Findings, Conclusions, and Basis Therefor

This hearing was conducted using documents contained in the ECF, and the oral arguments presented by the parties' representatives. Any documents contained in the folder are hereby incorporated into this hearing. I have reviewed all relevant exhibits contained in the ECF maintained by the American Arbitration Association.

Based on the materials submitted for my review, I find that Applicant's claims were submitted to and received by Respondent, and therefore that Applicant has demonstrated a prima facie case of entitlement to the disputed no fault benefits. See, Viviane Etienne Med. Care, P.C. v. Country Wide Ins. Co., 2013 NY Slip Op. 08430 (2nd Dept. 2013).

Regarding those claims that are allegedly subject to requests for additional verification, I note that if an insurer requires any additional information to evaluate the proof of claim, such a request for verification must be made within 15 business days of the receipt of the bill in order to toll the 30-day period to pay or deny the claim. See generally, 11 NYCRR 65-3.5(b); See also, New York Hosp. Med. Ctr. of Queens v. Allstate Ins. Co., 2014 NY Slip Op 00640 (2nd Dept. 2014). Where there is a timely original request for verification, but no response to the request for verification is received within 30 calendar days thereafter, or the response to the original request for verification is incomplete, then the insurer, within 10 calendar days after the expiration of that 30-day period, must follow up with a second request for verification. Id. If there is no response to the second, or follow-up, request for verification, the time in which the insurer must decide whether to pay or deny the claim is indefinitely tolled. Id. When there is a timely outstanding request for appropriate verification, arbitration of a pending claim is premature and should be denied without prejudice. However, it is within the Respondent's discretion, pursuant to 11 NYCRR §65-3.8(b)(3), to issue a denial "if, more than 120 calendar days after the initial request for verification, the applicant has not submitted all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply."

In the present case, the outstanding verification requests at issue apply to only two of the bills submitted by Applicant. Both of those bills pertain to office visits and are in the identical amounts of 64.07. Applicant's bill for the office visit dated 10/15/18 was denied based on the claim that Applicant failed to respond to verification requests within 120 days. Applicant's bill for the office visit dated 10/4/18 was never paid or denied based on the claim of outstanding verification. The verification requests and responses with respect to both bills are identical. The requested materials included medical records

together with certain financial and business information and documentation, including the names and addresses of all individuals and entities that perform management, consulting, advertising, marketing, transportation, accounting, billing, and collection services on behalf of the applicant, and copies of any and all agreements entered into with said individuals or entities. I note that, based on the evidence submitted for my review, only a single verification request was sent to the applicant regarding each of the two bills in question. The single verification request with respect to the bill for services rendered on 10/4/18 is dated 11/23/18. I note that the bill itself was received by the Respondent on 11/5/18. The single verification request for the services rendered on 10/15/18 is dated 1/15/19. I note that the bill itself was received by the Respondent on 11/20/18. Thus, the verification requests themselves do not appear to have been issued in accordance with the rules and regulations applicable to such requests, at least insofar as it can be determined based on the evidence submitted by the Respondent. See, 11 NYCRR 65-3.5 and 3.6.

I note, in any event, that the Applicant appears to have responded to all of the Respondent's then outstanding verification requests on 3/22/19, and that there is no indication or claim that the Respondent ever replied to the Applicant's response. I note that Applicant's verification response included some of the materials and information requested by the Respondent, and also included objections to providing certain other materials and information requested by the Respondent. I note that Respondent has not submitted any evidence concerning why the information and materials that were objected to by the Applicant were needed in order to process the Applicant's claim. I note, moreover, that substantially the same verification requests and responses at issue herein have been addressed repeatedly in several recent Awards. See, for example, Case No.'s 17-19-1140-7088, 17-19-1134-4412, 17-19-1131-4620, 17-19-1133-3296, and 17-19-1133-6388. In each of those awards, Arbitrator O'Connor noted the particulars of the verification requests at issue. Arbitrator O'Connor noted that the Applicant responded to each item listed in the verification requests, either providing the requested documentation or objecting to the requests. Arbitrator O'Connor found that the information provided by Applicant was arguably responsive to the Respondent's verification requests. Arbitrator O'Connor also noted that the Respondent had apparently ignored the Applicant's verification response. Accordingly, Arbitrator O'Connor upheld the Applicant's claims.

The parties herein have agreed that substantially the same facts and circumstances that were applicable in the cases decided by Arbitrator O'Connor are also applicable in the present case. After having reviewed the materials submitted in the present case, I find, for essentially the same substantive reasons articulated by Arbitrator O'Connor, that Applicant's verification responses were substantially compliant with the Respondent's verification requests. I also find, particularly in the absence of any evidentiary showing by the Respondent that it had a reasonable, good faith basis for issuing the particular verification requests that remain outstanding, that the objections raised by Applicant to those requests were appropriate. I note that when a provider objects to a request for verification, then the issue of whether the requested verification was material and the objections to the same were proper is preserved, and become questions of fact for the trier of fact. Victory Medical Diagnostics v. Nationwide Property and Casualty Co., 36 Misc.3d 568, 949 N.Y.S.2d 855 (Dist. Ct. Nass. Co. 2012). I also note that there is no

provision in the No-Fault regulations which permits a claimant or an insurance company to ignore communications from the opposite party without risking the chance of the non-responding party to prevail in the matter. See, Back to Back Chiropractor, P.C. v. State Farm Mutual Automobile Ins. Co., 35 Misc.3d 1241(A), (Dist. Ct. Suffolk Co., C. Stephen Hackeling, J., June 15, 2012). Accordingly, I find that the Respondent has failed to show that the presently disputed bills were appropriately delayed for payment or denial by outstanding requests for verification, and so find that Applicant is entitled to reimbursement of the two bills presently at issue. I note, with respect to the single bill that was never paid or denied, that the Applicant has agreed that interest on that bill should run from the date of the arbitration request.

With respect to the two surgical procedures performed on 9/27/18 and 10/8/18, I note that reimbursement for those procedures has been denied by the Respondent based on a peer review. The burden of production initially lies with the Respondent to establish a prima facie case of lack of medical necessity. Respondent's burden can be satisfied by a peer review report which sets forth both a factual basis and medical rationale for the asserted denial. See, generally, Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006).

To establish the defense of lack of medical necessity, Respondent relied on the peer review reports of Dr. Ajendra Sohal, a Physiatriist. Dr. Sohal has submitted two reports, one dated 11/26/18 and another dated 12/1/18. The earlier report addresses the medical necessity of the 9/27/18 lumbar discectomy. The later report addresses the medical necessity of the 10/8/18 cervical discectomy. I note that both reports and both procedures have previously been the subject of awards in which the issue of the medical necessity of those procedures has been determined adversely to the present Respondent.

In my own Award addressing the medical necessity of the 9/27/18 procedure, I found that the Applicant in that case had proven the medical necessity of the 9/27/18 lumbar discectomy by a preponderance of the credible evidence. See, Case No. 17-19-1116-3957. In Case No. 17-19-1119-4049, Arbitrator Ehrlich addressed the medical necessity of the 10/8/18 cervical discectomy. Arbitrator Ehrlich was not persuaded by Dr. Sohal's peer review report and instead deferred to the opinions contained in the rebuttal report of the Assignor's treating surgeon, Dr. William Jones. Arbitrator Ehrlich found in favor of the Applicant regarding the medical necessity of the 10/8/18 cervical discectomy and associated services. I note that the evidence presented with respect to both procedures in the present case is substantially the same evidence that was presented in the earlier cases ending in 3957 and 4049.

The doctrine of Collateral Estoppel provides that a party may be precluded from re-litigating an issue that has been determined in a prior arbitration, whether or not the tribunals or causes of action are the same. See, Ryan v. New York Telephone, 42 N.Y.2d 494, 478 N.Y.S.2d 823, 467 N.E.2d 487 (1984). Under New York law, courts require proof of two elements to invoke collateral estoppel: 1) an identity of issues which were necessarily decided in the prior action that are decisive in the present action, and 2) a full and fair opportunity by the party against whom collateral estoppel is being invoked to have contested the issue previously decided and now claimed to be

controlling (see Comprehensive Med. Care of NY, P.C. v Hausknecht, 55 AD3d 777, 778 [2008], citing Buechel v Bain, 97 NY2d 295, 303-304 (2001)). Collateral estoppel will operate to bar only issues that were actually litigated or necessarily decided in the prior proceeding. See, McGee v J. Dunn Constr. Corp., 54 AD3d 1009, 1009-1010 (2008); Chisholm-Ryder Co. v Sommer & Sommer, 78 AD2d 143, 144 (1980). The party against whom preclusion is sought bears the burden of demonstrating the absence of a full and fair opportunity to contest the prior determination. City of New York v College Point Sports Assn., Inc., 61 AD3d 33, 42 (2009); Buechel, 97 NY2d at 304.

In the present case, no argument has been advanced as to why the previous Awards referred to hereinabove should not have preclusive effect upon the issue of medical necessity raised by Respondent in the present case. There is no claim that the issues raised by Respondent in the present case are distinguishable from the same issues raised by Respondent in the earlier cases. There is no claim that any new or additional evidence has been submitted in the present case. There is no claim that the Respondent did not have a full and fair opportunity to litigate the issues presented herein in the context of the earlier cases. Accordingly, I adhere to the decisions in the previous cases cited hereinabove pursuant to the doctrine of Collateral Estoppel.

I have also conducted a de novo review of the evidence submitted in the present case, including the peer review reports of Dr. Sohal and the rebuttal reports of Dr. Jones. I find, irrespective of the doctrine of Collateral Estoppel, that the Applicant has credibly rebutted the conclusions put forward by the Respondent's peer reviewer with respect to the subject of medical necessity. For substantially the same reasons already set forth in my own previous case ending in 3957, I find that I am more persuaded by the opinions of the Assignor's treating physician than by the opinions expressed by Respondent's peer reviewer. For substantially the same reasons expressed by Arbitrator Ehrlich in the case ending in 4049, I also defer to the opinion of the Assignor's treating physician in determining the medical necessity of the cervical discectomy performed on 10/8/18. Accordingly, I find that the present Applicant has proven the medical necessity of both disputed procedures by a preponderance of the credible evidence.

Turning to the fee schedule issues raised by the Respondent, I note that Respondent has the 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, (Civil Ct, Kings Co. 2006). In support of its fee schedule defense, Respondent has submitted the affidavit of a certified professional coder, Stephanie Brown. Ms. Brown states that the Applicant's bills for the two surgeries at issue should amount to no more than 12,026.25. In response, Applicant has submitted the affidavit of Mary Beth Perdikos, who does not appear to be a certified professional coder, but who says that she has substantial training and professional experience regarding the Workers' Compensation Fee Schedule. Ms. Perdikos calculates that Applicant's surgical bills should total 17,557.84, an amount significantly lower than the total amount originally billed by Applicant. I note that Applicant has amended its claim for the surgeries at issue to the amount proposed by Ms. Perdikos, and that the Applicant's total amended amount in controversy, 17,685.98, includes the aforementioned claims for the two office visits in the total amount of 128.14.

I note that the difference between the amounts proposed by the parties herein is completely accounted for by the disparate treatment afforded by the parties' respective affidants to 4 codes: 62287, 63075, 63076, and 62291. I note that Code 62287 is applicable only to the bill for the 9/27/18 lumbar procedure. Codes 63075, 63076, and 62291 are applicable only to the 10/8/18 cervical procedure. With regard to the 9/27/18 lumbar procedure, Respondent's coder says that code 62287 is included in another code billed by the Applicant, 22526, and so is not entitled to separate compensation. Applicant disagrees, and claims that it is owed full payment for both codes. I note that the amount proposed by the Applicant relative to the 9/27/18 services, inclusive of the services of both the primary and assistant surgeon, is 8,244.21. The amount proposed by the Respondent for those services, including "zero" for code 62287, is 5,226.02.

With respect to the 9/27/18 surgery, Respondent's coder states that code 62287 is "not to be reported when billed with code 22526...as [code 62287 is] considered to be inclusive to code 22526." In support of that statement, Respondent's coder refers to the Complete Global Service Data for Orthopedic Surgery, but she says nothing further substantively regarding any restrictions that may be imposed on code 62287. Respondent's coder has attached a single page excerpt from the Global Service Data for Orthopedic Surgery to the text of her affidavit. That excerpt contains a list of services included in the "global services package" for code 22526. The list of 13 items includes "percutaneous decompression, e.g. 62287". No substantive explanation regarding the treatment of codes 62287 and 22526 is included in any of the materials submitted by Respondent. I note that code 22526 refers to a percutaneous intradiscal electrothermal procedure, and that code 62287 refers to a "decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material...with the use of an endoscope..."

In response, Ms. Perdikos' affidavit emphasizes that Respondent's coder relies on the Complete Global Service Data for Orthopaedic Surgery as the sole basis for disallowing reimbursement of CPT code 62287. Ms. Perdikos notes, however, that it is the NYS Workers' Compensation Fee Schedule in conjunction with the CPT Assistant, and not the Complete Global Service Data for Orthopaedic Surgery, that governs reimbursement for NYS No Fault claims. Ms. Perdikos notes that nowhere in either the NYS Workers' Compensation Fee Schedule or the CPT Assistant does it state that CPT Code 62287 should not be billed in conjunction with CPT Code 22526. She says that, as per the NYS Workers' Compensation Fee Schedule and the CPT Assistant, Codes 62287 and 22526 are separate and distinct codes.

In several previous cases, 17-19-1116-1662 and 17-18-1112-4588, I noted that the Complete Global Service Data source cited by the Respondent's coder appeared to be a private publication issued by the American Academy of Orthopedic Surgeons, and that there is no indication that such a publication had been adopted in any official capacity by the New York Workers' Compensation Board. I noted then, as I note again now, that a number of other arbitrators have found that there is no authority requiring the use of that source in the context of New York No Fault claims, and that the Global Service Data publication is not generally recognized as controlling in a New York No Fault forum. See, for example, Case No.'s 17-18-1100-6610, 17-17-1072-4262, 17-18-1099-3938, and 17-18-1107-3257.

The law is clear that the Respondent must "conclusively demonstrate" the proper fee schedule rate of payment for the services rendered in a "coherent manner". See, Viviane Etienne Med. Care, P.C. v. Country-Wide Ins. Co., supra. In the present case, Respondent's coder has submitted only a brief, conclusory statement to the effect that code 62287 is included within code 22526. I note that the validity of that statement is not self evident from the plain language of the code descriptions continued in the fee schedule. I note that the Respondent's coder does not cite or refer to the CPT Assistant or any other equivalent authority in support of her conclusion that code 62287 is included within code 22526. I note, with respect to the Respondent's reliance on the Complete Global Service Data publication, that I am persuaded by the objections raised in the Applicant's fee schedule affidavit, which are consistent with the views expressed by myself and other arbitrators in the cases cited hereinabove. Accordingly, I find that the Respondent has failed to credibly establish that code 62287 is not compensable under the circumstances of the present case.

Nevertheless, I also find that the fee schedule affidavit submitted by the Applicant fails to address the applicability of the multiple procedures rule to the amount due to the Applicant for the 9/27/18 services at issue. I note that the actual fee schedule amounts claimed by Applicant for code 62287, 2,601.89 and 416.30, have not been disputed herein. I note that, if compensable, code 62287 would be the procedure with the highest allowance among the various procedures billed by the Applicant, and that the lesser procedures would therefore be payable at 50% of the fee schedule rate. I note that Applicant has claimed code 22526 at the full fee schedule rate of 2,489.66 for the primary surgeon, and 398.35 for the surgical assistant. Given that Applicant is also claiming full payment for code 62287, however, Applicant's bill for code 22526 should be reduced by 50%, to 1,244.83 and 199.18. I note that code 22527, for which Applicant also billed the full fee schedule amount, is an add-on code and so is not subject to reduction pursuant to the multiple procedures rule. Accordingly, I find that Applicant's bill for the 9/27/18 procedure may appropriately include the amount of 3,018.19 (2,601.89+416.30) for code 62287. I also find that Applicant's bill for code 22526 must be reduced by half, from 2,888.01 to 1,444.01 (1,244.83+199.18). Applicant's calculations of the amount presently due for the 9/27/18 procedure, 8,244.21, must therefore also be reduced by 1,444.01 to 6,800.20. I note that the 50% reduction in the amount payable for code 22526 is consistent with the credible calculations contained in other Awards involving similar bills submitted by the present Applicant. See, for example, Case No.'s 17-19-1140-2601, 17-18-1088-4053, 17-18-1105-4262, and 17-16-1046-0710.

With respect to the 10/8/18 cervical procedure, I note that Applicant calculates a total amount due of 9,313.63, which once again includes the fee for both the primary and assistant surgeon. By contrast, Respondent states that only 6,800.23, inclusive of both the primary and assistant surgeon's fees, is presently due to the Applicant. I note parenthetically that the 10/8/18 surgical services were performed in New Jersey after the effective date of the relatively recent amendment to 11 NYCRR 66.8, which limits compensation for out of state services for New York residents to the lowest of the highest applicable New York rate or the locally applicable rate. I also note that the previously discussed 9/27/18 surgical services were performed in New York. There is no

issue, however, as to which rate of payment is applicable to the 10/8/18 services. Both parties agree that the New York rate of payment is applicable to both dates of service at issue herein.

With regard to the contentions set forth by the parties in their respective fee schedule affidavits, I note that the calculations submitted by Respondent's coder all involve a change to one of the codes billed by the Applicant. Respondent's coder has changed code 63075 to code 0274T, and has adjusted the amount due to Applicant accordingly. Respondent's coder also proposes a "zero" amount of compensation for codes 63076 and 62291, stating that the latter codes may not be billed together with code 0274T.

Respondent's coder argues, based explicitly upon her own reading and interpretation of the relevant operative report, that the "correct" CPT code relative to the services billed by Applicant under code 63075 is actually code 0274T. I note that code 63075 refers to a cervical discectomy performed at a single level. Respondent's coder states that code 0274T refers to a percutaneous laminotomy/laminectomy for decompression of neural elements. Respondent's coder says that code 0274T is a By Report code, and so concludes that a comparison must be undertaken between that code and a listed code. Respondent's coder says that the appropriate code to use for that purpose is code 62287. Respondent notes that code 62287 refers to a decompression procedure performed at a single or multiple levels. Since code 63076 refers to a cervical discectomy performed at "each additional interspace", Respondent's coder concludes that code 63076 may not be billed along with code 62287. Respondent's coder then utilizes the correct fee schedule amounts for code 62287 in place and instead of the amounts billed by Applicant for code 63075 and 63076, reducing the amounts originally billed by Applicant for code 63075 from 3,289.01 to 2,601.89 relative to the primary surgeon, and from 3,289.01 to 416.30 relative to the surgical assistant. With particular respect to code 62291, Respondent's coder says that, "as per CPT AMA guidelines", code 62291 may not be reported together with code 0274T.

Ms. Perdikos notes in response that the fee schedule amounts for code 63075 have been correctly set forth in her affidavit. She states that Respondent has attempted to "improperly and incorrectly" change Applicant's billed CPT Code from 63075 to CPT Code 0274T, and then from CPT Code 0274T to CPT Code 62287. She notes that Code 62287 pertains to a lumbar spine decompression, and that the 10/8/18 procedure involved a cervical decompression. She argues that Respondent has not submitted any documentation or authority to support its use of CPT Code 0274T as opposed to code 63075. Ms. Perdikos notes specifically that Respondent has not uploaded the sections of the CPT Assistant pertaining to the billing of CPT Code 63075. She says that the only reporting restriction for CPT Code 63075 is to "not report 63075 in conjunction with 22554." Ms. Perdikos concludes that the Applicant is owed the correct fee schedule amounts of 3,289.01 and 526.24 for code 63075, 1,103.97 and 176.64 for code 63076, and 375.63 plus 60.10 for code 62291. Ms. Perdikos notes that the latter code was inappropriately disallowed by Respondent's coder based on its purported inclusion "in a code not billed by Applicant".

I note that Ms. Perdikos has appropriately reduced the amounts claimed by Applicant for code 62291 by applying the multiple procedures rule. I note that the multiple procedures

rule does not apply to code 63076, which is an add-on code. Ultimately, Ms. Perdikos indicates that a total sum of 5,531.59 is due to the Applicant by virtue of codes 63075, 63076, and 62291. I note that Ms. Perdikos' calculations appear to be in conformance with the applicable fee schedule. I note that none of the actual fee amounts or arithmetic calculations proposed by Ms. Perdikos' have been contradicted by the Respondent's coder. As per the affidavit of Respondent's coder, it is undisputed that Applicant is owed the additional sums of 1,244.83 and 199.17 for code 22526, and 2,015.55 and 322.49 for code 22527. According to the calculations put forward by Ms. Perdikos, Applicant would therefore be owed the aforementioned amount of 9,313.63 for the services rendered on 10/8/18.

Based on a careful review of all of the submitted materials, I am persuaded by the arguments presented in the Applicant's fee schedule affidavit. Ultimately, I am more persuaded by those arguments than by the arguments presented in the Respondent's fee schedule affidavit with respect to the services rendered on 10/8/18. I note that all of the Respondent's adjustments to the Applicant's bill for that date of service depend upon a unilateral code change from 63075 to 0274T. I also note, however, that an insurer's unilateral decision to change an applicant's CPT Codes, deny the claim or pay reduced fees for disputed medical services 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, denials and fee reductions. See, Amaze Medical Supply v. Eagle Insurance Company, 2 Misc 3d 128A (App Term 2d and 11th Jud Dist 2003). In the present case, I find that the fee schedule affidavit submitted by Respondent suffers from certain inadequacies in that regard, chief among those being the absence of an authoritative explanation or independent evidentiary support regarding the Respondent's proposed code change from 63075 to 0274T.

I note that code 0274T is a Category III code intended for use in cases involving new and emerging technologies that are not yet encompassed by established CPT codes. The reporting of Category III codes supercedes the reporting of existing unlisted codes relative to the same services. Category III codes are intended for temporary use only, with the ultimate goal that, following an appropriate period of investigation, the relevant Category III codes would be replaced by conventional, Category I CPT codes.

It is notable, particularly in light of the Respondent's initial burden to establish the validity of its fee schedule position in the view of a non-expert finder of fact, that Respondent's coder does not discuss or even refer to the subject of Category III codes in connection with her proposed code change from 63075 to 0274T. It may or may be the case that the presently disputed 10/8/18 discectomy involved an emerging, investigational treatment appropriately subject to a Category III code, but it is notable that Respondent's coder does not make that allegation in the course of her affidavit. Respondent's coder does not refer to or discuss the relevance of Category III codes to the treatment at issue herein. Respondent's coder does not explicitly argue that the 10/8/18 discectomy at issue did not meet the existing criteria for code 63075, which is an established, listed CPT code in the Workers Compensation Fee Schedule. Respondent's coder has not explicitly argued that code 63075 has been effectively replaced by code 0274T in the New York Workers' Compensation Fee Schedule or elsewhere. I note that, particularly in the absence of expert guidance, it is difficult to detect any obvious

incongruence between the fee schedule description of code 63075 and the language contained in the relevant operative report. I note that, while Respondent's coder has relied upon her own independent reading of the 10/8/18 operative report in support of her proposed code change, she acknowledges in the preamble to her report that "this auditor is not a medical professional able to make medical determinations on behalf of patient care." I note that the Respondent's peer reviewer, who is a medical professional, lists all of the codes billed by the Applicant in his report; he does not, however, offer any adverse comment upon the appropriateness of choosing any of those codes, including code 63075, to represent the services he discusses in that report. I note that the Respondent has not submitted any other Awards in which the presently disputed code change has been addressed. I note that Ms. Perdikos is correct in asserting that none of the excerpts from the CPT Assistant uploaded by the Respondent refer to a code change from 63075 to 0274T. I note that Respondent's coder has not submitted any documentation in support of her repeated references to "AMA Guidelines", at least insofar as they may impact the specific code change at issue herein.

Accordingly, based on the evidence submitted herein, I find that the Respondent has failed to credibly establish that a code change from 63075 to 0274T is mandated in this instance, and so find in favor of the Applicant with respect to the amount due for the services rendered on 10/8/18.

The Applicant's claim is therefore upheld in the amount of 16,241.97 (9,313.63+6,800.20+128.14).

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
	Phoenix Medical Services P.C. DBA Rockville Centre Pain Management & Rehabilitation	09/27/18 - 10/15/18	\$40,654.34	\$17,685.98	Awarded: \$16,241.97
Total			\$40,654.34		Awarded: \$16,241.97

- B. The insurer shall also compute and pay the applicant interest set forth below. 06/19/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Consistent with applicable regulations of the New York State Insurance Department, including 11 NYCRR 65-3.9 (c) and 11 NYCRR 65-4.2 (b), I find that Arbitration was requested on 6/19/19, and so find that interest shall accumulate from that date at the simple rate of 2 percent per month, calculated on a pro rata basis using a 30 day month.

C. Attorney's Fees

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

After calculating the sum total of the first-party benefits awarded in this arbitration plus the interest thereon, Respondent shall pay the applicant an attorney's fee equal to 20% of that total sum, subject to a maximum of \$1,360.00. See 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 New York

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

03/10/2021
(Dated)

John Langell

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
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