American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Professional Pain Management PC (Applicant)	AAA Case No.	17-19-1134-5337
	Applicant's File No.	2275895
- and -	Insurer's Claim File No.	000340139 001
	NAIC No.	10839
Country-Wide Insurance Company (Respondent)		

ARBITRATION AWARD

I, Eileen Hennessy, 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-E.S.

1. Hearing(s) held on 03/16/2021
   Declared closed by the arbitrator on 03/16/2021

   Catherine Ramsawak from Israel, Israel & Purdy, LLP (Great Neck) participated in person for the Applicant

   Ellen Maisto from Jaffe & Velazquez, LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 6,063.02**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated and agreed that (i) Applicant has met its prima facie burden by submitting evidence that payment of no-fault benefits is overdue, and proof of its claim was mailed to and received by Respondent and (ii) Respondent's denials of the subject claims were timely issued.

3. Summary of Issues in Dispute

   The record reveals that the Assignor-E.S., a 41-year-old male, claimed injuries as the driver of a motor vehicle involved in an accident that occurred on 10/10/2018. Applicant billed for three levels of bilateral lumbar medial branch block (LMBB)injections, a lumbar epidural steroid injection (LESI), trigger point injections (TPI), discograms,

lumbar percutaneous discectomy surgery, epidurograms, and fluoroscopic guidance conducted on 12/22/2018, 1/12/2019, and 2/9/2019. Respondent denied these claims based on a lack of medical necessity as determined by peer review reports of Miranda B. Smith, M.D., dated 2/20/2019, 3/11/2019, and 4/4/2019. Applicant billed for injectable medication in correlation with TPIs conducted on 11/13/2018 and 1/8/2019, which was denied premised upon the fee schedule. The issues to be determined are 1) whether the services are medically necessary and if so, 2) whether the services were billed in accordance with the Fee Schedule?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement forthree levels of bilateral LMBBinjections, a LESI, TPIs, discograms, a lumbar percutaneous discectomy surgery, epidurograms, fluoroscopic guidance, and injectable medication. This hearing was conducted using the documents contained in the Electronic Case Folder (ECF) for the case maintained by the American Arbitration Association. All documents contained in the ECF are made part of the record of this hearing and my decision was made after a review of all relevant documents found in the ECF as well as the arguments presented by the parties during the hearing.

In accordance with 11 NYCRR 65-4.5(o) (1), an arbitrator shall be the judge of the relevance and materiality of the evidence and strict conformity of the legal rules of evidence shall not be necessary. Further, the arbitrator may question or examine any witnesses and independently raise any issue that Arbitrator deems relevant to making an award that is consistent with the Insurance Law and the Department Regulations.

Legal Standards for Determining Medical Necessity

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. 2014). 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).

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, Kingsbrook Jewish Medical Center v. Allstate Ins. Co., 61 A.D.3d 13, 871 N.Y.S.2d 680 (2d Dept. 2009), such as by a qualified expert performing an independent medical examination or conducting a peer review of the injured person's treatment. *See* Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp., 2003 N.Y. Slip Op. 50842(U), 2003 WL 21049583 (App. Term 2d & 11th Dists. Apr. 1, 2003). The appellate courts have not clearly defined what satisfies the insurer's evidentiary standard except to the extent that "bald assertions" are insufficient. Amherst Medical Supply, LLC v. A Central Ins. Co., 41 Misc.3d 133(A),

981 N.Y.S.2d 633 (Table), 2013 NY Slip Op 51800(U), 2013 WL 5861523 (App. Term 1st Dept. Oct. 30, 2013). However, there are myriad civil court decisions tackling the issue of what constitutes a "factual basis and medical rationale" sufficient to establish a lack of medical necessity. The trial 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 generally* Nir v. Allstate Ins. Co., 7 Misc.3d 544, 547, 796 N.Y.S.2d 857, 860 (Civ. Ct. Kings Co. 2005); *See also*, All Boro Psychological Servs. P.C. v. GEICO, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012).

Where a respondent meets its burden, it becomes incumbent on the claimant to rebut the peer review. Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 139(A), 2008 WL 506180 (App. Term 2d & 11 Dists. Feb. 21, 2008); A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co., 16 Misc.3d 131(A), 2007 WL 1989432 (App. Term 2d & 11 Dists July 3, 2007. "[T]he insured/provider bears the burden of persuasion on the question of medical necessity. Specifically, once the insurer makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity, 'plaintiff must rebut it or succumb." Bedford Park Medical Practice, P.C. v. American Transit Ins. Co., 8 Misc.3d 1025(A), 2005 WL 1936346 at 3 (Civ. Ct. Kings Co., Jack M. Battaglia, J., Aug. 12, 2005). "Where 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* Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11 ed])." West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 2006 N.Y. Slip. Op. 5187(U) at 2, 2006 WL 2829826 (App. Term 2d & 11 Dists. Sept. 29, 2006).

Application of Legal Standards

In support of its contention that thethree levels of LMBBinjections, the LESI, TPIs, discograms, lumbar percutaneous discectomy surgery, epidurograms, and fluoroscopic guidance conducted on 12/22/2018, 1/12/2019, and 2/9/2019were not medically necessary, Respondent relies upon the peer reviews of Miranda B. Smith, M.D., dated 2/20/2019, 3/11/2019, and 4/4/2019. Arbitrator Bernadette O'Connor in*New Horizon Surgical Center LLC and Country-Wide Insurance Company*, AAA Case No.: 17-19-1128-3877, 9/29/2020,addressed the issue of medical necessity of the facility fees for the same underlying services rendered to Assignor-E.S. in dispute in this case, i.e., three levels of bilateral LMBBinjections, TPIs, and fluoroscopic guidance of the lumbar spine conducted on 12/22/2018; discography, epidurography, and fluoroscopic guidance conducted on 1/12/2019, and lumbar percutaneous discectomy surgery, epidurography, fluoroscopic guidance, discogram, and LESI conducted on 2/9/2019. The linked case was timely denied premised upon the same peer reviews of Miranda B. Smith, M.D., dated 2/20/2019, 3/11/2019, and 4/4/2019. The linked decision read in pertinent part:

Summary of Issues in Dispute

Applicant seeks reimbursement for medical services provided to the Assignor, a 41-year-old male, who sustained injuries to the neck and back in a motor vehicle accident on October 10, 2018: December 22, 2018: Nerve block and trigger point injections of the lumbar spine; January 12, 2019: Percutaneous discectomy; fluoroscopic guidance; discography; February 9, 2019: Percutaneous discectomy; fluoroscopic guidance. Respondent denied payment based on reports dated February 20, 2019, March 11, 2019 and April 4, 2019, by Miranda B. Smith, M.D. Respondent also argued that Applicant's billing for services rendered on December 22, 2018 exceeded the Workers' Compensation Fee Schedule.

The issues presented are whether the services rendered to the Assignor herein were medically necessary and whether Respondent has sustained its fee schedule defense.

Findings, Conclusions, and Basis Therefor

…

Miranda B. Smith, M.D., reviewed the medical records and concluded that the services rendered to the Assignor herein were not medically necessary. She opined that Applicant targeted an excessive number of injections by targeting three facet joints bilaterally. In order to determine whether the patient is experiencing facet-mediated pain, an initial and confirmatory injection should be performed, either as a diagnostic-intra-articular injection or a diagnostic medial branch block. Applicant did not perform either injection in this matter. Dr. Smith further indicated that the medical records show significant lumbar tenderness, but no lumbar trigger points in the form of taut bands with referral on palpation. She argued that "without the presence of true myofascial trigger points on examination, medical necessity cannot be established for the trigger point injections performed." Dr. Smith indicated the epidurography was not warranted in this matter. She also indicated that discography is not considered to be an effective tool in the pre-operative evaluation of patients undergoing surgery. She further opined that percutaneous discectomy "is not recommended as proof of its effectiveness has not been demonstrated."

In response to Dr. Smith's report, Mark Gladstein, M.D. issued rebuttal reports dated July 7, 2020. Dr. Gladstein argued that the services rendered in this matter were medically necessary due to the Assignor's symptomatology. He noted that the Assignor's back pain persisted. Examination of the lumbar spine revealed tenderness and positive straight leg raising test. An MRI study of the lumbar spine revealed disc herniation. The discography was performed to "reveal lumbar disc anatomy and tailor further treatment." Dr. Gladstein indicated that the epidurography was warranted in this matter to provide a safe and therapeutic epidural steroid injection. He noted that the medial branch block and trigger point injection were necessary for the treatment of the Assignor's pain. According to Dr. Gladstein, the lumbar discectomy was performed due to the Assignor's persistent symptoms of radicular/radiating pain, positive straight leg raising test, sensory deficits, paresthesias, and loss of motor strength.

Medical Necessity:

…

I find that Dr. Smith has set forth sufficient factual basis and medical rationale to support her conclusion that the services provided to the were not medically necessary.

Having found that Respondent's consultant has successfully rebutted Applicant's prima facie case of medical necessity the burden shifts back to Applicant to counter Dr. Smith's report, and demonstrate the necessity of the services at issue. CPT Med Services, P.C. v. New York Cent. Mut. Fire Ins. Co., 2007 New York Slip Op 27526, 18 Misc. 3d 87 (App Term 1st Dept.); Eden Med., P.C. v. Progressive Cas. Ins. Co., 2008 NY Slip, Op 51098 (U), 19 Misc.3d 143 (A) (App Term 2nd & 11th Jud Dists., 2008); Bath Med. Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 2008 NY Slip Op 50347 (U) (App Term 2d Dept., Feb. 26, 2008; Khodadadi Radiology v. New York Central, 16 Misc. 3d 131 (A) (2007).

After carefully reviewing the evidence presented, I find that Applicant has failed to meet its shifted burden of proof. The weight of the credible evidence supports a finding in favor of Respondent. Dr. Gladstein's report does not sufficiently rebut Dr. Smith's report and demonstrate that the services rendered herein were medically necessary.

While Arbitrator O'Connor's decision is not entitled to collateral estoppel, it is persuasive in this case. The same issue is in dispute in this case: whether three levels of bilateral LMBBinjections, TPIs, and fluoroscopic guidance of the lumbar spine conducted on 12/22/2018; discography, epidurography, and fluoroscopic guidance, conducted on 1/12/2019, and the lumbar percutaneous discectomy surgery, epidurography, fluoroscopic guidance, discogram, and the LESI conducted on 2/9/2019 are medically necessary? Arbitrator O'Connor held in the prior award that the reports of Dr. Smith are sufficient to support Respondent's denials based upon a lack of medical necessity as they maintain a factual basis and medically cogent rationale to support her opinion that the services at issue were not medically necessary. I concur with Arbitrator O'Connor's analysis. Therefore, the burden shifts to the Applicant to establish the services conducted on 12/22/2018, 1/12/2019, and 2/9/2019 were medically necessary.

Notably, according to the award, the Applicant in the linked case submitted a formal rebuttal by Mark Gladstein, M.D., dated 7/7/2020. In this case, Applicant submits a formal rebuttal by treating doctor, Nirmal Patel, M.D., dated 2/1/2021, along with examinations by Dr. Patel, dated 10/23/2018, 11/13/2018, 11/17/2018, 12/22/2018, 1/8/2019, 1/12/2019, 1/22/2019, and 2/9/2019, the MRI of the cervical spine, dated 10/25/2018, the MRI of the lumbar spine, dated 11/8/2018, operative reports for TPIs, dated 10/23/2018, 11/13/2018, 11/17/2018, 12/22/2018, 1/8/2018, and 1/22/2018, operative reports for LESI, dated 11/13/2018, 11/17/2018, 1/12/2019, and 2/9/2019, operative report for LMBB injections, dated 12/22/2018, operative report for lumbar discogram, dated 1/12/2019, and operative report for lumbar percutaneous discectomy and discogram, dated 2/9/2019.

Regarding the LMBB injections conducted on 12/22/2018, Dr. Patel states in the rebuttal in pertinent part:"that the patient was an appropriate candidate for lumbar

medial branch blocks because of symptoms and examination findings including lumbar facet tenderness and positive facet loading tests. I noted '[p]atient will be given post procedure pain evaluation form and will be instructed to monitor and complete this form for the lower back pain for next 48-72 hours to evaluate efficacy of this treatment and will also be instructed to return this completed form at post procedure follow up visit'." Dr. Patel further "disagree[d] with Dr. Smith's conclusion that a proper algorithmic approach for these diagnostic medial branch blocks was not used". He continued: "The procedure is primarily diagnostic, meaning that if the patient has the appropriate duration of pain relief after the medial branch nerve block, then he or she may be a candidate for a subsequent medial branch radiofrequency ablation for longer term pain relief".

Regarding the TPIs conducted on 12/22/2018, Dr. Patel states he noted: "in my December 22, 2018, examination report that there were taut muscle fibers and trigger points noted on examination. Further, its noted in the attached procedure report that two trigger points were identified prior to the injections. Thus, this patient was an appropriate candidate for trigger point injections, despite Dr. Smith's claim that trigger point injections and medial branch blocks should not be performed on the same day. These injections were performed for distinct indications, and the performance of one had no bearing on the other". Dr. Patel's rebuttal indicates at paragraph 7 that lumbar TPIs were also billed on 2/9/2019 in error.

Regarding the epidurogram conducted on 1/12/2019, Dr. Patel states: "Because of the high rate of erroneous needle placement associated with blind techniques (25%-30% of injections), epidurography is needed to document accurate needle placement and to evaluate the epidural space before the instillation of therapeutic substances"..."Fluoroscopic needle placement and epidurography provide visual confirmation of accurate needle placement, distribution of the injectate, and depiction of epidural disease. Epidurography in conjunction with epidural steroid injections provides for safe and accurate therapeutic injection and is associated with an exceedingly low frequency of untoward sequelae".

According to Dr. Patel's report, dated 1/8/2019, the discogram conducted on 1/12/2019 was recommended to "reveal lumbar disc anatomy to tailor further treatment". The rebuttal states: "Discography was appropriately used in this case to confirm the patient's candidacy for the percutaneous discectomy subsequently performed on February 9, 2019". "Indications for discography include, but are not limited to: (1) Further evaluation of demonstrably abnormal discs to help assess the extent of abnormality or correlation of the abnormality with the clinical symptoms…(2) Patients with persistent, severe symptoms in whom other diagnostic tests have failed to reveal clear confirmation of a suspected disc as the source of pain…(5) Assessment of candidates for minimally invasive surgical intervention to confirm a contained disc herniation or to investigate dye distribution pattern before percutaneous procedures."

Dr. Patel cites to several articles in support of his position that "Percutaneous discectomy's effectiveness is established in the treatment of symptomatic disc herniation like that diagnosed in this patient". He further indicates "[m]any surgeons routinely use ESI during lumbar discectomy to reduce traumatic nerve root inflammation and edema."

Citing to literature in support he states "The results of this study show a marked lasting reduction in lumbar pain following lumbar epidural steroid injections at multiple follow-up evaluations, with no major complications and a very low rate of minor complications. The results of this study confirm my clinical experience in administering epidural steroid injections and my professional opinion as their safety and efficacy" and "Transforaminal epidural steroid injection is a relatively simple, effective and low-risk alternative to surgical decompression for the treatment of lumbar disc herniation in selected cases".

In this matter, I am faced with conflicting opinions concerning the medical necessity for the disputed services. There are no legal issues to resolve. This dispute involves solely an issue of fact, that is, whether the services billed were medically necessary. Resolution of that fact is determined by which opinion is accepted by the trier of fact.

Comparing the relevant evidence presented by both parties as against each other, I concur with Arbitrator O'Connor and find for the Respondent. After careful review of the record, I find Respondent has set forth a factual basis and medical rationale for denying payment. Applicant has not successfully refuted Dr. Smith's peer reviews and her opinion that the LMBB, TPIs, discograms, and lumbar percutaneous discectomy surgery with LESI, were not medically necessary, nor has Applicant established that the disputed services were medically necessary. Dr. Patel provided intensive treatment to the Assignor with minimal benefit, including four LESIs conducted from 11/13/2018 through 2/9/2019, five rounds of lumbar TPI and one round of cervical TPI from 10/23/2018 through 1/22/2019, LMBB injections on 12/22/2019, and a lumbar percutaneous discectomy surgery conducted on 2/9/2019.

Regarding the LMBB injections and TPI on 12/22/2018, Dr. Patel fails to rebut Dr. Smith's peer review, which indicates "In this case, an excessive number of injection targets is depicted. Targeting three facet joints bilaterally is considered somewhat excessive when reviewing the literature of spine injection procedures. Typically, more targeted injection procedure approaches addressing the posterior elements of the cervical spine will be limited to one or two unilateral joint segments for a more focal diagnostic and potentially therapeutic spinal injection approach. In this case, the diagnosis of facet mediated pain remains speculative. The literature highlights the lack of reliability of physical examination, radiographic, and historical findings in assigning a diagnosis of facet-mediated pain. It is therefore accepted that an initial and confirmatory diagnostic injection should be performed in the form of either a diagnostic intra-articular injection or a diagnostic medial branch block. Such injections are to be performed with anesthetic alone and followed with an appropriate assessment to the patient's pain response following the diagnostic injection procedure. During the life of the anesthetic, the patient's response to typically provocative maneuvers can be assessed with a documentation of level of pain relief when compared to the pre-injection state. No such diagnostic injections were performed in this case, rather a therapeutic procedure with the injection corticosteroid is described. There is no role for therapeutic medial branch block injections". The operative report fails to establish that diagnostic injections were conducted with anesthetic alone and followed with an appropriate assessment to the

patient's pain response following the diagnostic injection procedure. "In this case, there is no inclusion of a pre and post injection pain score or pain diagram completed by the patient".

Dr. Smith further notes "It should also be noted that performing lumbar trigger point injections at the same time as the lumbar paravertebral nerve block further highlights the complete lack of diagnostic utility of the paravertebral nerve block procedure under review". I am persuaded by Dr. Smith that "Physical examination performed by the treating clinician was significant for lumbar tenderness, however lumbar trigger points in the form of taught bands with referral on palpation are not described. Without the presence of true myofascial trigger points on examination, medical necessity cannot be established for the trigger point injections performed". Specifically, the 12/22/2018 report notes inconsistent symptoms throughout. Specifically in the History section the report notes the patient complains of "low back pain and mid back with constant dull to sharp aching pain and weakness and decreased mobility and stiffness. Bending increases this pain. Unable to sleep due to this pain and has to use pillow between his legs to get comfortable. No pain lower extremity and tingling and numbness. VAS 8/10… Had LESI 2 weeks ago but no improvement in lower back pain". The physical examination notes "bilateral muscles trigger point", with "taut hypersensitive muscle bands causing shooting pain" in the cervical spine. The lumbar spine examination indicates tenderness and muscle spasm with no indication of trigger points or taut muscle bands. Meanwhile, aside from referencing neck pain, the Assessment section extensively details the lower back pain, which includes symptoms of tenderness, reduced range of motion, and aching pain shooting down to both buttocks and posterior thigh with positive facet loading, muscle spasm, and taut muscle spasm with trigger points. These symptoms are not documented in the examination section of the report. The Assessment section notes that lumbar TPIs were recommended to "reduce inflammation and pain, restore range of motion, and thereby facilitating progress to more active programs". The Assessment section notes trigger points and taut muscle bands of the lumbar spine, which is not referenced in the examination section yet there is no mention of the cervical trigger points and taut muscle bands causing shooting pain and tenderness which were referenced in the examination. The Assignor was referred for lumbar TPI but not cervical TPI. The Assessment section is inconsistent with the History and examination sections of the 12/22/2018 report and are not credible. Applicant failed to rebut Dr. Smith's findings regarding the LMBB injections and TPI conducted on 12/22/2018 and the claim is denied.

Regarding the discograms performed on 1/12/2019 and 2/9/2019, Dr. Patel fails to persuasively rebut Dr. Smith's findings, which indicate: "Given that discography has not proven to be an effective tool in the pre-operative evaluation of patients undergoing surgery or IDET, its use in this case is not considered medically necessary. In addition, there is a high likelihood of adverse effects on the target disc or on adjacent nonpathological disc levels". She further notes "In the past, discography has been used as part of the pre-operative evaluation of patients for consideration of surgical intervention for lower back pain. However, the conclusions of recent, high-quality studies on discography have significantly questioned the use of discography results as a preoperative indication for either IDET or spinal fusion. These studies have suggested that reproduction of the patient's specific back complaints on injection of one or more

discs (concordance of symptoms) is of limited diagnostic value. (Pain production was found to be common in non-back pain patients, pain reproduction was found to be inaccurate in many patients with chronic back pain and abnormal psychosocial testing, and in this latter patient type, the test itself was sometimes found to produce significant symptoms in non-back pain controls more than a year after testing.) Also, the findings of discography have not been shown to consistently correlate well with the finding of a High Intensity Zone (HIZ) on MRI".

I note that Applicant billed for a discogram (code 62290) on 1/12/2019 and again on 2/9/2019, the date of the lumbar percutaneous discectomy surgery, although the rebuttal references only the first discogram conducted on 1/12/2019. The two reports have different outcomes. Specifically, the 1/12/2019 discogram indicates "at L4/L5 level there was left contained disc herniation with left low back pain and no leg pain". Meanwhile, the 2/9/2019 operative report indicates "discogenic pain as patient complained of pain on injection and revealed left posterior leak into the epidural space". If the discogram was conducted to "reveal lumbar disc anatomy to tailor further treatment", "to confirm the patient's candidacy for the percutaneous discectomy subsequently performed on February 9, 2019", and as an "Assessment of candidates for minimally invasive surgical intervention to confirm a contained disc herniation or to investigate dye distribution pattern before percutaneous procedures", as indicated by the rebuttal and examination reports, why were two discograms conducted? Moreover, why would a discogram be conducted during the surgery if the purpose is to determine whether the patient is a candidate for surgery? Applicant's rebuttal citation indicates the discogram is to confirm that the patient has a "contained disc herniation" to be a candidate for the surgery, yet the discogram performed during the surgery on 2/9/2019 indicates the disc is leaking into the epidural space. Applicant's records are inconsistent with the rebuttal. Furthermore, there is no explanation as to why two discograms were conducted and why they have completely different outcomes. Applicant failed to rebut the peer review or establish the medical necessity of the procedures. Therefore, the discograms and attendant services billed on 1/12/2019 and 2/9/2019 are denied.

Dr. Smith recommended reimbursement for the LESI (code 64483) conducted on 1/12/2019 but denied reimbursement for the corresponding epidurogram (Code 72275) stating: "The use of epidurography is not clinically indicated in this case, is not recommended as the primary fluoroscopy code, and such reporting is not likely to affect outcomes, or the procedure performed beyond the information obtained through the use of image guidance with contrast enhancement. Clinically, this case did not appear to present a need for additional imaging beyond that realized with the use of fluoroscopy and contrast enhancement to confirm satisfactory flow of the injectate and an absence of vascular uptake. Additionally, the patient's injection procedure was appropriately preceded by MRI imaging which demonstrated the suspected corroborative focal disc pathology, neural impingement, and any regional (foraminal, lateral recess, or central canal) stenosis which might compromise achieving a more classic peri-radicular and epidural dye pattern. Therefore, a more formal epidurography procedure is not clinically indicated in this, nor is such interpretation likely to affect clinical outcomes". Applicant billed code 64483, whihc is described as "Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level". The code includes fluoroscopic imaging guidance. I am persuaded by Dr.

Smith's analysis that the use of fluoroscopic guidance was sufficient to confirm needle placement and to "confirm satisfactory flow of the injectate and an absence of vascular uptake". Dr. Patel's indication that the epidurogram "provides a safe and accurate placement of this therapeutic injection" is insufficient to rebut Dr. Smith's analysis and establish the need for this code. Moreover, Applicant's "Interpretation of the epidurogram" report fails to meet the code description.

Specifically, I take note of the following CPT Assistant articles which address this procedure:

> Fluoroscopic Guidance with Epidurography and Sacroiliac Joint Arthrography
> July 2008; Volume 18: Issue 7
>
> > Code 72275, Epidurography, radiologic supervision and interpretation, is used to report a diagnostic radiologic procedure for the performance, supervision, interpretation, and documentation of epidurography. This code should be used only when a diagnostic epidurogram is performed. Hardcopy images in multiple planes documenting the flow of contrast must be obtained, and a formal radiologic report must be prepared. The code for epidurography should be distinguished from code 77003, which is intended for the use of fluoroscopic imaging for guidance and localization of needle placement for a diagnostic or therapeutic injection procedure (eg, an epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint injection). The use of code 72275 is for diagnostic purposes and is not indicated or appropriate to use for needle localization in the majority of therapeutic epidural steroid injections or similar procedures in lieu of code 77003. If the procedure for code 72275 is performed, code 77003 is considered part of this code and is not reported separately. . .
> >
> > The indications for the use of diagnostic epidurography are limited. The vignette associated with code 72275 for the AMA/Specialty Society Relative Value Scale Update Committee (RUC) describes the use of epidurography to determine whether there are obstructions in the epidural space that would limit the spread of therapeutic substances that may be injected, such as a neurolytic substance for chemical rhizotomy. The data obtained from the diagnostic epidurography should influence and improve patient treatment options and contribute new information to that already obtained from other spinal imaging procedures commonly used, such as magnetic resonance imaging and computed tomography with myelography. Epidurography should not be used routinely for localization with the performance of most therapeutic spinal injection procedures, as this is best addressed by code 77003.
> >
> > Code 72275 includes code 77003 and is reported only when an epidurogram is performed, images are documented, and a formal radiologic report is issued…

> Radiology/Diagnostic Radiology (Diagnostic Imaging)

October 2009; Volume 19: Issue 10

Question: During various injections of therapeutic substances into the spine, contrast is often injected to ensure that the needle or catheter is in the epidural space. Is it appropriate to code 72275, Epidurography, radiologic supervision and interpretation, in addition to the appropriate injection code?

Answer: No. Code 72275 is only to be used when an epidurogram is performed, images documented, and a formal radiologic report issued. A statement indicating that contrast flows in the epidural space would only document localization and would not represent a diagnostic epidurogram. The introductory language in Surgery/Nervous System for Spine and Spinal Cord, under Injection, Drainage, or Aspiration in the CPT 2009 states that "injection of contrast during fluoroscopic guidance and localization is an inclusive component of codes 62263- 62264, 62267, 62270-62273, 62280-62282, 62310-62319. Fluoroscopic guidance and localization is reported with 77003, unless a formal contrast study (myelography, epidurography, or arthrography) is performed, in which case the use of fluoroscopy is included in the supervision and interpretation codes" (CPT 2009, p 270).

Radiology: Radiologic Guidance

February 2010; Volume 20: Issue 2

Question: What is the difference between CPT codes 72275, Epidurography, radiological supervision and interpretation, and 77003, Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction?

Answer: Code 72275 (epidurography) differs from code 77003 (fluoroscopic guidance) in that it represents a formal contrast study that includes fluoroscopy. Code 77003 represents fluoroscopic guidance and localization used in spine or paraspinous injection procedures, so it is reported in addition to the code for the injection procedures when the injection procedure does not include fluoroscopic guidance. It is inappropriate to report code 77003 in addition to code 72275.

While these localization or radiological supervision and interpretation codes are not add-on codes, typically another service is reported by the same or another physician. This is because they do not include the injection services (eg, code 62310 for the injection component of cervical epidurography or 62281 for the therapeutic injection). However, the injection of small amounts of contrast to assist in the localization services described by 77003 is not separately reported. Rather it is part of the service for the injection of the diagnostic or therapeutic substance for which localization is required.

I note that CPT Assistant is a source which must be considered when evaluating a claim for No-Fault benefits. *See* Matter of Global Liberty Ins. Co. v. McMahon, 172 A.D.3d 500, 99 N.Y.S.3d 310, 2019 NY Slip Op 03692 (App. Div., First Dept., May 9, 2019).

Code 72275 is only to be used when an epidurogram is performed, images documented, and a formal radiologic report issued. CPT 72275 may be reported when a diagnostic procedure is rendered with a formal radiologic report with hardcopy images. Assignee submits an operative report with its claim submissions for the epidural injection (64483) and the epidurography (72275). The epidural injection operative report and epidurogram interpretation report indicate that an epidurography was rendered during the injection. However, Assignee has not rendered a diagnostic epidurography as the reports are limited to the spread of contrast. Therefore, Assignee may not separately report an epidurography under CPT 72275. I find that Applicant has failed to establish that the services billed under code 72275 were rendered as billed. The report states that an epidurogram was performed, with images documented, and formal radiologic reports issued to establish that this procedure was performed but this documentation was not submitted to the record to substantiate this report. Therefore, code 72275 was properly denied, and the denial is sustained.

Regarding the percutaneous discectomy and LESI, Dr. Smith notes: "A systematic review found that current evidence does not support the routine use of minimally invasive surgery for cervical or lumbar discectomy. Minimally invasive surgery had no clinically significant advantage in terms of short-or long-term measures of pain or function. Patients who underwent minimally invasive disc surgery had higher levels of nerve root injury, dural tears, and reoperation. According to the authors, surgeons already perform open discectomies through relatively small incisions, so it is not surprising to find that outcomes are no better with minimally invasive discectomies". She further notes: "Percutaneous discectomy (PCD) is not recommended because proof of its effectiveness has not been demonstrated. The performance of an IDET procedure and the description of concordant pain with an annular tear also suggest that these more speculative interventions were offered for a prevailing axial pain complaint. Disc decompression would rather be intended for a compressive radiculopathy and not for axial pain alone". "In this case, there is no role for a concomitant transforaminal epidural steroid injection as was performed. The claimant does not describe radicular pain. Physical examination does not support the presence of a lumbar radiculopathy in the form of a myotomal strength deficit, dermatomal sensory deficit, or focal reflex abnormality".

Dr. Patel disagrees that the procedure is not effective and cites to multiple articles but does not correlate these articles with the Assignor's symptoms or rebut that the Assignor was not a candidate for the surgery based on the clinical findings. He cites to an article, which states:"Automated percutaneous discectomy may be considered for the treatment of lumbar disc herniation with radiculopathy."However, Dr. Patel fails to rebut Dr. Smith's position that the Assignor's neurological examination results do not support a diagnosis of radiculopathy. Multiple examinations indicate that the Assignor has no pain in the lower extremity and notes complaints that are axial in nature yet Dr. Patel diagnoses radiculopathy in the Assessment sections. Dr. Patel's 12/22/2018 report notes "Had LESI two weeks ago but no improvement". The other examinations similarly note minimal benefit from the LESIs, which were conducted on 11/13/2018 and 1/12/2019, yet the Assignor was referred for four LESIs in under four months and lumbar percutaneous discectomy surgery. The 1/12/2019 discogram, which Applicant indicates

they used to determine whether the Assignor was a candidate for the surgery, states: "at L4/L5 level there was left contained disc herniation with left low back pain and no leg pain", which is inconsistent with radiculopathy. I do not find Dr. Patel's examination reports credible or persuasive as the examination findings for each of Dr. Patel's examinations from 10/23/2018 through 2/9/2019 have identical range of motion findings, neurological examination findings, and orthopedic examination findings, despite updated History and Assessment sections. Despite undergoing LMBB injections, three LESIs, and multiple rounds of TPIs prior to the lumbar percutaenous discectomy surgery conducted on 2/9/2019 there is no change in the examination findings, which calls into question the credibility of the reports. Moreover, despite no change in the examination findings and minimal improvement in the Assignor's condition or pain score, Dr. Patel continues to recommend TPIs and LESIs. Dr. Patel fails to rebut Dr. Smith's findings or establish that the lumbar percutaneous discectomy surgery and LESI were medically necessary. The claim for the surgery, LESI, and attendant services billed on 2/9/2019 are denied.

Comparing the relevant credible evidence presented by both parties against each other, and the above-referenced standards, I concur with Arbitrator O'Connor's analysis of Dr. Smith's peer reviews. I also find that the Applicant has failed to meet its burden of persuasion in rebuttal. The peer reviews are sufficient to sustain the defense of lack of medical necessity for the services billed. Applicant's claims for dates of service 12/22/2018, 1/12/2019, and 2/9/2019 are denied.

FEE SCHEDULE

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). Amended Regulations section 65-3.8(g)(1) states proof of the fact, and amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances: (i) when the claimed medical services were not provided to an injured party; or (ii) for those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers. This subdivision applies to medical services rendered on or after April 1, 2013.

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).

An insurer's unilateral decision to re-code or change a medical provider's billed CPT codes, to reimburse disputed medical services at a reduced rate, or to deny a claim in its entirety, 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, fee reductions and denials. *See* Amaze Medical Supply v. Eagle Insurance Company, 2 Misc 3d 128A (App Term 2d and 11th Jud Dist 2003). A lay person is not qualified to evaluate the CPT codes or to change if the code is used by a health provider in its bills. *See* Abraham v. Country-Wide Ins. Co., 3 Misc. 3d. 130A (App. Term 2d. Dept. 2004). Once the insurer establishes a prima facie showing that the amounts charged by a provider were in excess of the fee schedule, the burden shifts to the provider to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. Cornell Medical, P.C. v. Mercury Casualty Co., 24 Misc. 3d 58, 884 N.Y.S.3d 558 (App. Term 2d, 11th &13th Dists. 2009).

Judicial notice of the New York Fee Schedule is taken. *See*, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 20 (2d Dept. 2009); LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A) (App Term 2d, 11th & 13th Jud Dists. 2011); Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A) (App Term, 1st Dept. 2011).

ANALYSIS

Code J0702

Applicant billed one unit of HCPCS code J0702 ($35.00) in conjunction with TPIs conducted on 11/13/2018 and 1/8/2019. Respondent denied the claims for code J0702 stating:"The provider's fee exceeds the maximum allowance under the applicable fee schedule and is reduced accordingly".

"An insurer who raises this defense will prevail if it demonstrates that it was correct in its reading of the fee schedules unless the plaintiff shows that 'an unusual procedure or unique circumstance justifies the necessity' for a charge above the schedules fee. 11 NYCRR 68.4." Jesa Medical Supply, Ind. V. Geico Ins. Co., 2009 NY Slip Op. 29386, 25 Misc. 3d 1098, (Civ. Ct. Kings Co. 2009).

I find Respondent's EOBs are sufficient to establish a prima facie showing that the amount charged by Applicant was in excess of the fee schedule for HCPCS code J0702. The burden now shifts to Applicant to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. *See*, Cornell Medical, *supra*.

Ground Rule #16 of the Surgery Fee Schedule provides: "Do not report supplies that are customarily included in surgical packages, such as gauze, sponges, steri-strips, and dressings. Surgical services do not include the supply of medications, sterile trays, and

other materials which may be reported separately with code 99070. The specific items provided must be identified. Payment shall not exceed the invoice cost of the item, applicable taxes, and any shipping and handling costs associated with delivery from the supplier of the item to the physician's office. There should be no additional 'handling' costs added to the total cost of the item. Bill using procedure code 99070."

Pursuant to Ground Rule #16, the medication should have been billed using 99070 and must be billed at the invoice cost of the item. An affidavit from a certified coder or other expert is not necessary because the language of the ground rule is clear. While the correct code was not utilized Applicant submitted an invoice from Clint Pharmaceuticals, dated 4/19/2018, which indicates that Betamethasone, the injectable medication billed, cost $49.19 per vial. Applicant billed $35.00 for the medication, which is less than the invoice cost. Consequently, Applicant submitted credible proof to support the billing for this item and therefore met the criteria set forth in the Fee Schedule. Therefore, as there is no dispute that the medication was provided and Applicant substantiated the amount billed through the invoice, Applicant is entitled to reimbursement despite billing the incorrect code. Thus, Applicant's claims for CPT code J0702 ($35.00) billed on 11/13/2018 and 1/8/2019 are granted.

CONCLUSION

Accordingly, Applicant's claim is granted in the amount of $70.00. The remainder of the claim is denied. This decision is in full disposition of all claims for No-Fault benefits presently before this arbitrator.

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
	Professional Pain Management PC	**11/13/18 - 02/09/19**	**$6,063.02**	**Awarded: $70.00**
Total			**$6,063.02**	**Awarded: $70.00**

B. The insurer shall also compute and pay the applicant interest set forth below. 07/08/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. *See generally*, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30-day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." *See*, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009). Based on the regulations, interest shall accrue from the date the applicant requested arbitration in this matter. *See*, 11 NYCRR 65-3.9(c).

C. Attorney's Fees

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

Applicant is entitled to an attorney's fee pursuant to Insurance Law §5106(a). After calculating the sum total of the first-party (No-Fault) benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, subject to the following limitations: In the event the above filing date was prior to Feb. 4, 2015, the attorney's fee is subject to a minimum of $60.00 and a maximum of $850.00, per 11 NYCRR 65-4.6(e). In the event the above filing date was on or after Feb. 4, 2015, the attorney's fee is subject to a maximum of $1,360.00, per 11 NYCRR 65-4.6(d). In the event the above filing date was on or after Feb. 4, 2015 and first-party (No-Fault) benefits are awarded to more than one Applicant herein, the

attorney's fee shall be calculated separately for each Applicant, each Applicant's attorney fee being subject to the $1,360.00 maximum.

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

04/15/2021
(Dated)

Eileen Hennessy

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:
b6cf2fb83562826a8e0fab89929a49e8

Electronically Signed

Your name: Eileen Hennessy
Signed on: 04/15/2021