American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Tri-Borough NY Medical Practice PC (Applicant)	AAA Case No.	17-21-1222-3034
	Applicant's File No.	n/a
- and -	Insurer's Claim File No.	0541891390101013
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Bonnie Link, 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: the EIP

1. Hearing(s) held on 06/07/2022
   Declared closed by the arbitrator on 06/07/2022

   Mark Fenelon,Esq. from The Law Offices of Hillary Blumenthal P.C. (Melville) participated in person for the Applicant

   Robert Barnes, Esq. from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$1,400.78**, 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

   This arbitration arises out of treatment of a 45 year old male for injuries sustained in a motor vehicle accident that occurred on June 8, 2021. Applicant seeks reimbursement in the amount of $1400.78 for extracorporeal shock wave therapy conducted on July 2, 2021. Respondent timely denied the bills based on a Peer Review by Samuel Carli dated September 1, 2021 that found that the treatment was not medically necessary.

   A rebuttal dated April 25, 2022 by Leonid Shapiro, M.D. is submitted and reviewed.

   The Respondent's attorney argues that if medical necessity is found, then the proper reimbursement for the procedure based on the fee schedule is $700.39.

Initially the award for date of service 6/23/21 was submitte in error. A technical correction was reuested by the undersinged. THe TC was granted and the correct award uploaded.

4. Findings, Conclusions, and Basis Therefor

This matter is determined after reviewing the documents contained in the electronic case folder at the closing of the file and the presentations of both sides. The hearing was conducted via ZOOM and all parties appeared.

It is well settled that an applicant establishes its prima facie entitlement to payment by proving it submitted a claim setting forth the facts and the amount of the loss sustained and that payment of no fault benefits were overdue (see Insurance Law § 5106[a]; Mary Immaculate Hospital v Allstate Ins. Co. 5 A.D.3d. 742 Second Dep't 2004. A prima facie case has been established herein.

According to the submissions, the EIP was a restrained driver who did not seek or receive emergency medical services. The following day, she was examined by Inna Letvenko NP for complaints of pain in her neck, low back and left shoulder. The findings were restriction in ranges of motion, positive orthopedic testing, tenderness and spasms. He was commenced on a regimen of physical therapy and acupuncture. One week later, he had MRIs of his cervical and lumbar spines and left shoulder.

The EIP had the subject extracorporeal shock wave therapy for her cervical spine and left shoulder. A linked matter shows that he had an earlier session, on June 23, 2021. See, AAA Case #172112208221.

Dr. Carli reviewed the records, including the physical therapy and acupuncture SOAP notes and the MRIs. He determined that the subject shockwave therapy was not medically necessary. He explained that the procedure is "sort of ultrasonic treatment in which the applied tissue is bombarded with ultrasound for an extended period of time." He also said it was "highly recommended for treating calcific rotator cuff tendonitis" but is "not recommended for pain relief in general." Finally, he stated that shockwave therapy "is normally regarded as a secondary conservative approach to persistent musculoskeletal disorders that are recalcitrant to conventional care."

As for this patient, Dr. Carli stated that "the medical necessity for extracorporeal shockwave therapy has not been proven in this care because neither the required diagnosis/condition nor the failure of conservative care, such as medications, rest, ice application and other traditional therapies has been recorded."

An insurance carrier must at a minimum establish a detailed factual basis and a sufficient medical rationale for asserting lack of medical necessity, Delta Diagnostic Radiology PC v. Progressive Casualty Ins. Co., 21 Misc. 3d. (142A) (App. Term 2d. Dep't, 2008), and "must set forth a factual basis sufficient to establish, prima facie, the

absence of medical necessity." Choicenet Chiropractic P.C. v. Allstate Ins. Co., 2003 N.Y. Slip Op. 50672[U], 2003 WL 1904296 (App. Term, 2d and 11th Jud. Dists. 2003) (emphasis supplied).

"Where the defendant insurer presents sufficient evidt one for which the therapy would be medically necessary. While Dr. Carli stated that the patient did not have the diagnosis/condition for which the therapy would be medically necessary, he did not discuss what those diagnoses/conditions are, and he failed to discuss the treatment that the patient had up to that point. He did not mention the diagnosis that the patient had, nor did he mention the findings in the left shoulder MRI. While he mentioned certain treatments, he did not establish a standard of care or how it was violated.

Dr. Carli's peer review does not contain a sufficient "factual basis and medical rationale" to support a medical necessity defense.

Based on the foregoing, I find that the Respondent has not met its burden of proving the lack of medical necessity. The peer review is perfunctory, conclusory and unpersuasive. The "discussion" simply does not credibly incorporate the case history into the opinion that is being rendered.

The Applicant billed $1400.78 for the administration of this treatment to 2 body parts, the cervical spine and left shoulder. It billed $700.39 per unit and used CPT code 0101T and 0101T-59.

The Respondent argues that it should only have to reimburse the Applicant "once" for the total treatment. It submitted a fee schedule affidavit by Crystal Russo, CPC, and employee of GEICO, dated March 8, 2022 to support the request for the reduction. Ms. Russo analyzed the treatment and stated that "the Applicant provider is only entitled to one unit of extracorporeal shock wave therapy per day."

She based her opinion on her analysis of the fee schedule. She states that CPT code 0101T is a category III code and is a By Report code without an assigned Relative Value Unit. The fee schedule requires the provider to establish the RVU relative to other procedures. She found that the procedure is akin to 28890, which is for shock wave treatment for plantar fasciitis which has an RVU of 2.79. Accordingly, the procedure, conducted by a medical doctor would be valued at $700.39 (which is what the Applicant billed per unit.)

As for multiple units, she states that this code should only be billed once for all body areas involving the musculoskeletal system on a single date of service.

The description of fee code 0101T is "Extracorporeal shock wave involving musculoskeletal system, not otherwise specific, high energy." As such, the coder explained that this code should only be billed once for the musculoskeletal system (meaning the entire system, all parts) on a single date of service. Based on this analysis, the coder asserts that the Respondent should be paid $639.02.

In East Coast Medical Care, PC and Allstate Property and Casualty Insurance Company, AAA Case No. 17-21-1198-9800 (4/25/22), Arb. Antonietta Russo found that the conclusion that this code can only be billed once because "it involves the musculoskeletal system" is unsupported. There is nothing within the code descriptor indicating that this can only be billed once. Indeed, the fee schedule contains myriad codes that specifically indicate the number of extremities, nerves, or times a service may be performed. The fact that this code is silent as to how many times it may be billed is indicative of the fact that there is no limitation. Respondent's contention that there is "only one musculoskeletal system", and therefore it can only be billed once is misplaced. This is a surgical code and there is no limitation indicated other than the multiple procedure rule and other ground rules."

In Chand Medical PC and Geico Insurance Company, AAA Case No. 17-21-1221-5039, (5-2-22), Arb. Paul Weinbaum found "I find Ms. Russo's rationale persuasive in establishing that extracorporeal shockwave therapy is to be reimbursed only once per day for the entire musculoskeletal system. If the fee schedule intended reimbursement for each body region then there would have been a carveout as detailed in CPT code 0102T for the elbow."

On the other hand, in Metropolitan Medical and Surgical, P.C. and State Farm Mutual Automobile Insurance Company, AAA Case No. 17-21-1218-4373 (4/2/22), Arb. Allison Schimel stated "CPT 0101T cannot be billed more than once per day, since the code includes the musculoskeletal system. I note that CPT 0101T is not defined by the AMA CPT as a 'per anatomic site' treatment, as it involves the musculoskeletal system, which encompasses multiple muscles and ligaments. Hence, I find that based upon a plain reading of the fee schedule, only one unit of service per day is allowed."

I am swayed by the coder affidavit and the plain reading of the code and the understanding of the service (the use of an electric wand to deliver the wave therapy) and prior awards that the service should only be billed once. It is unreasonable to find that the lifting of a wand from the skin on one part of the body and placing it down on another should be considered a separate treatment.

The Applicant has not offered anything sufficient to rebut the Respondent's proof. Accordingly, the Applicant is awarded one unit @$700.39.

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**
	Tri-Borough NY Medical Practice PC	**07/02/21 - 07/02/21**	**$1,400.78**	**Awarded: $700.39**
Total			**$1,400.78**	**Awarded: $700.39**

B. The insurer shall also compute and pay the applicant interest set forth below. 10/11/2021 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The denial in this matter being timely issued, the Respondent shall pay the Applicant interest on the amount of first-party benefits awarded, computed from date of filing, to the date payment is made at a rate of 2% per month, simple interest (i.e., not compounded) using a 30 day month, subject to the provisions of 11 NYCRR 65-3.9(c).

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C. Attorney's Fees

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

As this matter was filed after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 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 Nassau

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

07/05/2022
(Dated)

Bonnie Link

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:
4f8694c98d90e3b17ce4e47274c3da8c

Electronically Signed

Your name: Bonnie Link
Signed on: 07/05/2022