

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Metropolitan Medical and Surgical, P.C.
(Applicant)

- and -

LM General Insurance Company
(Respondent)

AAA Case No. 17-22-1236-3263

Applicant's File No. 55145

Insurer's Claim File No. 0430340410004

NAIC No. 36447

ARBITRATION AWARD

I, Nancy Kramer Avalone, 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 CSM

1. Hearing(s) held on 03/13/2023
Declared closed by the arbitrator on 03/13/2023

John Gallagher, Esq. from The Law Offices of John Gallagher, PLLC participated virtually for the Applicant

Greg DeNezzo, Esq. from LM General Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$5,094.97**, was NOT AMENDED at the oral hearing.
Stipulations WERE NOT made by the parties regarding the issues to be determined.
3. Summary of Issues in Dispute

The instant dispute arose out of a motor vehicle accident that occurred on 06/20/2020 involving Assignor CSM, a 21-year old female, as a rear-seated passenger. The claim consists of three dates of service: 08/16/2021 for a discectomy at \$4991.07; and 08/12/2021 for "Hand spec for transfer fr [sic] office to a lab" at \$35.08 and an office visit on 09/10/2021 at \$68.82. The office visit was denied as not medically necessary based on an Independent Medical Examination by Sammy Dean, MD. The discectomy was denied as not medically necessary based on the peer review of Michael E. Tawfello, MD, Board Certified in Anesthesiology and Pain Management. Respondent also asserted that the fees were in excess of the New York State Workers' Compensation

Medical Fee Schedule ("fee schedule"). The claim for 09/10/2020 was denied based on the fee schedule. Respondent submitted a fee schedule analysis by Melissa Simon, Certified Professional Coder.

The issues presented are as follows: whether the office visit and/or the discectomy were medically necessary. If the answer is in the affirmative regarding the surgery, then determining the proper reimbursement for the surgery; and whether the Respondent sufficiently established its fee schedule defense regarding the services provided on 08/12/2020.

There were no issues raised with respect to the submission of the claims or the issuance of the denial of claim forms. After reviewing of the Record, I find that Applicant submitted timely proof of claims and Respondent issued timely denial of claim forms preserving all defenses contained therein.

4. Findings, Conclusions, and Basis Therefor

The instant matter was decided based upon the submissions of the parties as contained in the electronic file ("E-file") maintained by the American Arbitration Association (MODRIA), and the oral arguments of the parties' representatives. The hearing was held via a web-based video conferencing platform (ZOOM). I have reviewed the documents contained in the E-file, heard the arguments of the parties, and make my decision in reliance thereon.

Pursuant to 11 NYCRR §65-4.5(o)(1), an arbitrator shall be the judge of the relevance and materiality of the evidence offered. The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations. (*See Med. Socy. v Serio*, 100 NY2d 854 [2003]).

Medical Necessity Issue.

Under Sec. 5102 of the New York Insurance Law (McKinney 1985), No-Fault first party benefits are reimbursable for all medically necessary expenses on account of personal injuries arising out of the use or operation of a motor vehicle.

Lack of medical necessity is a valid defense to an action to recover No-Fault benefits. (*AJS Chiropractic, P.C. v Travelers Ins. Co.*, 25 Misc 3d 140[A], 2009 NY Slip Op 52446[U] [App Term 2009]).

The Respondent must, at a minimum, establish a detailed factual basis and a sufficient medical rationale for its asserted lack of medical necessity. (*Delta Diagnostic Radiology, P.C. v Progressive Cas. Ins. Co.*, 21 Misc 3d 142[A], 2008 NY Slip Op 52450[U] [App Term 2008]).

Additionally, it must be proven that said rationale is supported by evidence of the generally accepted medical/professional practices. (*Nir v Allstate Ins. Co.*, 7 Misc 3d 544 [Civ Ct, Kings County 2005]).

When the insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the Applicant/provider which must then present its own evidence of medical necessity. (*See generally, W. Tremont Med. Diagnostic, P.C. v Geico Ins. Co.*, 13 Misc 3d 131[A], 2006 NY Slip Op 51871[U] [App Term 2006]).

Where the denial is predicated upon a peer review report, and the peer review report establishes *prima facie*, that there was no medical necessity for the services performed, the provider must refute the peer review doctor's determination. (*See A Khodadadi Radiology, P.C. v NY Cent. Mut. Fire Ins. Co.*, 16 Misc 3d 131[A], 2007 NY Slip Op 51342[U] [App Term 2007]).

Similarly, where the insurer denies the claim based upon an Independent Medical Examination (IME) of the Assignor, and the IME establishes *prima facie* that there was no medical necessity for continued treatment, the Applicant/provider bears the burden of demonstrating that the treatment at issue was medically necessary by a preponderance of the credible evidence. (*See Amato v State Farm Ins. Co.*, 40 Misc 3d 129[A], 2013 NY Slip Op 51113[U] [App Term 2013])

Factual Findings.

Date of service 08/16/2021. In support of the lack of medical necessity defense for the discectomy, the Respondent relied upon the peer review report of Dr. Tawfellow, dated 09/22/2021, in which the doctor concluded that the surgery was not medically necessary. He stated that the standard of care for a cervical spine injury begins with a reasonable trial of conservative treatment which consists of an evaluation by the physician, prescribing activity modification if necessary, encouraging return to activity as much as possible, prescription of medications such as anti-inflammatory medications, and conservative physiotherapy for a period of 4-6 weeks, followed by another modified course of therapy and exercises program if the patient is not responding to the initial course of treatment. Also imaging study to rule out cervical spondylolysis, or joint narrowing/spinal stenosis, which may be followed by an Epidural steroid injection (ESI) in order to avoid surgery and finally simple discectomy.

Dr. Tawfello then cited to an article discussing the surgical package requirements before billing postoperative care , and concluded that the surgery was not medically necessary , nor was the cervical injury caused by the subject accident based on the fact that there was a small gap in the medical records when cervical pain was not documented.

At no time did Dr. Tawfello discuss the actual procedure other than stating that it was cervical discectomy of the C5-C6 disc, cervical discectomy of the C6-C7 disc and fluoroscopy by Arden M. Kaisman, M.D., under monitored anesthesia care. Dr.

Tawfellos did not address the standard of care for performing a cervical discectomy nor the circumstances when this type of surgery was necessary.

At no time did Dr. Tawfellos discuss the results of the cervical MRI studies which revealed straightening of the physiologic lordosis consistent with pain and/or spasm. At C5-C6 there is central herniation impressing on the CSF column and causing secondary mass-effect on the spinal cord. At C6-C7 there is central disc herniation impressing on the CSF column. Again, Dr. Tawfellos did not discuss the cervical ligament laxity test which stated the following: Ligamentous instability is present in the cervical spine. Interruptions of George's line at C2-C3, C3-C4, C4-C5 and C5-C6 during the lateral stress views (flexion/extension) are indicative of ligamentous instability, sub-failure, or insufficiency from the evaluation of translational motion. The Assignor had two months of conservative care and underwent injections by Dr. Etienne. The report then fell short of a discussion of the standard of care for the surgery performed. Additionally, the peer reviewer did not explain a relationship between the clinical findings and the pre-operative diagnosis of herniated discs at C5-C6, C6-C7 and cervical radiculopathy.

Accordingly, I deem the peer review insufficient to establish lack of medical necessity. This is because the peer review did not conform with the requirements set forth in *Nir v Allstate Ins. Co.*, 7 Misc 3d 544 [Civ Ct, Kings County 2005] and its progeny. "To sustain a defense of lack of medical necessity, Defendant must also show that the services were inconsistent with generally accepted medical/professional practices, an expert opinion alone is insufficient to carry the burden (*citation omitted*)."
(*Bernhard J. Sengstock, DC, PC v Travelers Home & Mar. Ins. Co.*, 2017 NY Slip Op 32204[U], *5 [Civ Ct, Bronx County 2017]).

"To sustain a defense of lack of medical necessity, Defendant must also show that the services were inconsistent with generally accepted medical/professional practices, an expert opinion alone is insufficient to carry the burden (*citation omitted*)."
(*Surgicare Surgical Assoc. of Fair Lawn v State Farm Fire & Cas. Co.*, 2017 NY Slip Op 32202[U], *6 [Civ Ct, Bronx County 2017]).

Therefore, I find in favor of the Applicant. The fee schedule will be addressed below.

Date of service 09/10/2021. Applicant submitted a bill in the amount of \$68.82 for an examination by Dr. Christy Perdue. Respondent asserted a medical necessity defense as all future No-Fault benefits were terminated on 09/02/2021 based on the Independent Medical Examination by Sammy Dean, MD. The IME was conducted on 06/17/2021. At the exam, the Assignor advised that she was seated in the rear seat when the car was struck in the rear. She advised that following the accident she felt neck pain with numbness to her hands. She presented with complaints of pain in the mid back with radiation to the upper back and tingling in the hands. Dr. Dean evaluated the Assignor testing ranges of motion and orthopedic tests. There were no positive clinical findings and the examining physician concluded that all injuries were of the sprain/strain type and had resolved and that no future treatment was medically necessary.

In light of the fact that there are no contemporaneous evaluation reports (including no report found for date of service 09/10/2021), I find that the Respondent has established lack of medical necessity for continued treatment in this particular case. The claim for the office visit on 09/10/2021 is denied.

Fee Schedule Issue.

The Respondent submitted a fee schedule analysis which addressed the fees for the cervical discectomy provided on 08/16/2021 and the miscellaneous services provided on 08/14/2021.

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, (*Robert Physical Therapy, P.C. v State Farm Mut. Auto. Ins. Co.*, 13 Misc 3d 172 [Civ Ct, Kings County 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, (*Cont. Med., P.C. v Travelers Indem. Co.*, 11 Misc 3d 145[A], 2006 NY Slip Op 50841[U] [App Term 2006])

The undersigned arbitrator is permitted to take judicial notice of the Worker's Compensation fee schedule. See, (*Kingsbrook Jewish Med. Ctr. v Allstate Ins. Co.*, 61 AD3d 13 [2d Dept 2009]); (*Med. Socy. v Serio*, 100 NY2d 854 [2003])

Once the insurer makes 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 Med., P.C. v Mercury Cas. Co.*, 24 Misc 3d 58 [App Term 2009])

The bill for the cervical discectomy was as follows:

CPT code 63075 at \$3,617.86;

CPT code 63076 at \$1214.35;

CPT code 77003 at \$158.86.

Respondent relied on the fee schedule analysis conducted by Melissa Simon RN, ASN, BSN, CPC-Certified Professional Coder. Coder Simon stated the following:

Code 63075 & 63076 is paid to comparable code 62287 x 1 as a percutaneous decompression was performed using a "Stryker Dekompressor discectomy probe". Code 63075 is for an OPEN incisional procedure. Per the AMA CPT lay description of code 63075, it

states in part that "the physician makes a transverse incision overlying the intervertebral disc..".

Thus the coder merged all three codes into CPT code 62287. Taking judicial notice of the fee schedule the undersigned arbitrator notes the following: CPT code 62287 is described in the Surgery Chapter of the fee schedule as follows:

"Decompression procedure, percutaneous, of nucleus pulposus of intravertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, **lumbar**" [Emphasis added.]

The surgery was performed on the cervical spine and the operative report clearly delineated the levels in the cervical spine where the surgery was performed. As a result, I reject the analysis by Coder Simon.

The plain reading of the CPT codes in the applicable fee schedule are as follows:

CPT 63075: Discectomy, anterior, with decompression of the spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace. The RVU is 14.36.

CPT 63076: Discectomy, anterior, with decompression of the spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure). The RVU is 4.82.

The multiplier for Region IV where the provider is located is 251.94. For CPT 63075 we have 14.36×251.94 , for a total of \$3617.86. For CPT 63076 the total is \$1214.35.

CPT code 77003 is located in the Radiology Chapter of the fee schedule. The proper reimbursement for this service is \$158.86.

Therefore, I find that Applicant is awarded the sum of \$4991.07 for the surgery.

Date of service 08/12/2021. Applicant's bill contains CPT code 99000 in the amount of \$35.08 and the services are described as for "Hand spec for transfer fr [sic] office to a lab" by Mark Gladstein, MD. Essentially, the clinical responsibility for CPT code 99000 involves any work your practice has to perform to prepare a specimen for transportation to a laboratory per the agreement your practice has with that lab.

Respondent's Coder gave the correct analysis. She advised that there was \$0.00 reimbursement for this service. Coder Simon referred to Ground rule 9 in the Pathology and Laboratory chapter of the fee schedule. Ground Rule 9 advises one to refer to the 99000 services for handling and/or transfer of specimens. The 99000 services can be found in the Medicine Chapter. Specifically, CPT code 99000 states, "Handling and/or conveyance of specimen for transfer from the office to a laboratory. However, there is a

"NC" for this code. In the fee schedule "NC" refers to charges which are not covered in the State of New York. Thus, there is no reimbursement for this service. The claim is denied.

In conclusion, Applicant is reimbursed for the services provided on 08/16/2021 in the sum of \$4991.07.

This award is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

Applicant is entitled to statutory interest, attorney fees and the filing fee, as set forth in Sections 6. B, C and D, below.

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
	Metropolitan Medical and Surgical, P.C.	09/10/21 - 09/10/21	\$68.82	Denied
	Metropolitan Medical and	08/16/21 -	\$4,991.07	Awarded:

	Surgical, P.C.	08/16/21		\$4,991.07
	Metropolitan Medical and Surgical, P.C.	08/12/21 - 08/12/21	\$35.08	Denied
Total			\$5,094.97	Awarded: \$4,991.07

- B. The insurer shall also compute and pay the applicant interest set forth below. 01/24/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from the **date noted above** until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty-day month.

C. Attorney's Fees

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

Respondent shall pay the Applicant attorney's fees in accordance with 11 NYCRR §65-4.6(d). As this matter was filed **after 02/04/2015**, this case is subject to the provisions promulgated by the Dept. of Financial Services in the Sixth Amendment to 11 NYCRR §65-4 (Ins. Reg. 68-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 NY

SS :

County of Nassau

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

03/19/2023
(Dated)

Nancy Kramer Avalone

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:
c030badfe924f35500a93d1ae4e1bbf7

Electronically Signed

Your name: Nancy Kramer Avalone
Signed on: 03/19/2023