American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Jacqueline Escobar-Marshall PC (Applicant)	AAA Case No.	17-22-1260-6490
	Applicant's File No.	2974
- and -	Insurer's Claim File No.	0667856982
	NAIC No.	29688
Allstate Insurance Company (Respondent)		

ARBITRATION AWARD

I, Jeffrey Silber, 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: EIP

1. Hearing(s) held on 03/22/2023
   Declared closed by the arbitrator on 03/22/2023

   Maria Shteysel, Esq. from Shteysel Law Firm, P.C. (Long Island) participated virtually for the Applicant

   Michael Rago, Esq. from Law Office Of Lawrence & Lawrence participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,803.76**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Claim was amended to include only the dry needle treatment balance.

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

3. Summary of Issues in Dispute

   Whether Applicant is entitled to any additional reimbursement for the dry needling performed on 5/18/22 which was partially reimbursed and denied the balance based upon a fee schedule defense?

4. Findings, Conclusions, and Basis Therefor

The case was decided on the submissions of the Parties as contained in ADR Center maintained by the American Arbitration Association and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in the ADR Center for both parties and make my decision in reliance thereon.

The EIP, IW, a 23-year-old female was involved in a motor vehicle accident on April 29, 2022. The EIP was seen for an examination and dry needling treatment on 5/18/22. The Respondent made a partial payment for the examination and treatment, denying the balance on a fee schedule defense. Applicant is only seeking the balance of the dry needle treatments.

Applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue. See, Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case.

The burden now shifts to respondent to establish a lack of medical necessity with competent medical evidence which sets forth a clear factual basis (specifics of the claim) and medical rationale for denying the claim. Citywide Social Work and Psych Services, PLLC v. Allstate, 8 Misc. 3d 1025A (2005); Healing Hands Chiropractic v. Nationwide Assurance Co., 5 Misc. 3d 975 (2004). In order to satisfy its burden of proof, the respondent must offer sufficient and credible medical evidence that addresses the standards in the applicable medical community for the services and treatment in issue; explains when such services and treatment would be medically appropriate, preferably with an understandable objective criterion; and why it was not medically necessary in the instance at issue.

The insurer must establish a factual basis and medical rationale for its asserted lack of medical necessity, which is supported by evidence of the generally accepted medical/professional practices. Beal Medea Products Inc. v. Geico, 27 Misc. 3d 1218 (A), 910 NYS 2d 760 (Civ. Ct. Kings County 2010). Failing to mention the applicable generally accepted medical/professional standard and the plaintiff's departure from it denudes the defendant's proof of a prima facie case of lack of medical necessity. Cambridge Medical, PC v Geico, 18 Misc. 3d 1144 (A), 859 NYS 2d 893 (Civ. Ct. Richmond County 2008).

FEE SCHEDULE

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 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 NY Slip Op 50393U, 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 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curiam, 2006).

Regarding the dry needling, Applicant submits an affidavit from Carolyn Mallory, a certified fee coder from Signet Claim Solutions, LLC. Applicant billed for the dry needling using CPT code 20999, which is a "by-report" code and has no assigned value. Ms. Mallory opines that trigger point injections are the closest procedures to dry needle insertions in the Fee Schedule. She then concluded that the total that can be billed for three or more trigger point injections into muscles a day is $131.01. Since the services were provided by a nurse practitioner the provider is entitled to 80% of the physician rate, and the amount for dry needling services is $104.81. She provides no real explanation as to how she calculated this RVU. The Respondent made a payment for 80% of the charge for the office examination and $104.81 for the dry needling.

Applicant did counter with a fee coder of its own by Olesya Malyuta, a certified professional coder. Ms. Malyuta's affidavit addresses Ms. Russo 's review. Ms. Malyuta contends that Ms. Russo is incorrect to say that Code 20533 should have been utilized because trigger point injections is a different procedure than dry needling. Ms. Malyuta argues that dry needling should be billed at $75-100 per muscle due to the skill, time, expertise and complexity of procedure involved. Ms. Malyuta notes that trigger point injections take a few minutes while each dry needle take 5 minutes and since multiple muscles are injected dry needling can takes 45 minutes to 1 hour. Ms. Malyuta states that CPT Code 20999 was billed because there is only one session and because there were three or more muscles injected with needling. She also talks about how dry needling is compared to trigger point injections, which makes the affidavit confusing as it argues both sides of the comparable argument.

After reviewing the Fee Schedule, and upon comparing the relevant evidence submitted by the parties, I find that Respondent has met its burden of coming forward with competent evidentiary proof in support of its fee schedule defense. I am persuaded by Respondent that Applicant is not entitled to additional reimbursement for the disputed services. Overall, the weight, credibility and persuasiveness of the evidence favors Respondent and, as such, Applicant's claim for further reimbursement 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 claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of NY
SS :
County of Kings

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

03/26/2023
(Dated)

Jeffrey Silber

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:
3f780918debb7eca76473623b3c8cde6

Electronically Signed

Your name: Jeffrey Silber
Signed on: 03/26/2023