American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

| | | |
|---|---|---|
| New York Medical Monitoring PC (Applicant) | AAA Case No. | 17-22-1274-8744 |
| | Applicant's File No. | n/a |
| - and - | Insurer's Claim File No. | 7002963081-1-3 |
| | NAIC No. | 21687 |
| Mid-Century Insurance Company (Respondent) | | |

**ARBITRATION AWARD**

I, Cathryn Ann Cohen, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD:**

Injured Person(s) hereinafter referred to as: Assignor

1. Hearing(s) held on 11/01/2023
   Declared closed by the arbitrator on 11/01/2023

   Kim Gitlin, Esq. from Dino R. DiRienzo Esq. participated virtually for the Applicant

   Sue-Ann Rowley, Esq. from Law Offices of Rothenberg & Romanek participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$22,448.69**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount in dispute was amended to $5,581.87 per fee schedule, reducing the fee for code 95938 to $683.79 from $12,677.99 and reducing the fee for code 95861 to $316.38 from $5,189.00.

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

3. Summary of Issues in Dispute

   Applicant seeks $5,581.87 reimbursement of charges for SSEP studies, code 95938 at $683.79, EMGs, code 95861 at $316.38 and continuous intraoperative neurophysiology monitoring from outside the operating room, code 95941 at $4,581.70 provided in

connection with cervical discectomy and fusion surgery at C4-6 performed on June 20, 2022 on Assignor a 55-year-old male passenger involved in a motor vehicle accident on June 5, 2021.

Respondent timely denied reimbursement based on a peer review by Howard Levy, M.D. dated July 11, 2022, opining the services provided to Assignor were not medically necessary.

In addition, by checking box 18, Respondent argues the fees are not in accordance with the fee schedule.

4. Findings, Conclusions, and Basis Therefor

Applicant seeks $5,581.87 reimbursement of charges for SSEP studies, code 95938 at $683.79, EMGs, code 95861 at $316.38 and continuous intraoperative neurophysiology monitoring from outside the operating room, code 95941 at $4,581.70 provided in connection with cervical discectomy and fusion surgery at C4-6 performed on June 20, 2022 on Assignor a 55-year-old male passenger involved in a motor vehicle accident on June 5, 2021. Respondent timely denied reimbursement based on a peer review by Howard Levy, M.D. dated July 11, 2022, opining the services provided to Assignor were not medically necessary. In addition, by checking box 18, Respondent argues the fees are not in accordance with the fee schedule. I have reviewed the documents in the ADR Center record of the case maintained by the AAA as of the date of the hearing.

It is well settled that a health care provider establishes a prima facie case of entitlement to recover first-party no-fault benefits by submitting 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 was overdue. (*see, Insurance Law Sec.5106[a]; Mary Immaculate Hosp v. Allstate Ins. Co.,* 5 AD3d 742 [2004]). Respondent's denial(s) indicating receipt of the proof of claim shows that Applicant mailed the proof of claim form(s) to the Respondent ( *see, Ultra Diagnostic Imaging v. Liberty Mutual Insurance Co.*, 9 Misc.3d 97). The evidence is sufficient to make out a prima facie case of entitlement to recovery of Applicant's bill.

Once Applicant has established a prima facie case the burden shifts to the insurer to prove that the medical treatment was not medically necessary (*see Citywide Social Work & Psychological Services v Allstate Ins. Co.*, 8 Misc3d 1025A; *A.B. Medical* Services, *v Geico Ins. Co.*, 2 Misc3d 26). Neither the Insurance Law nor the Regulations define "medical necessity." A review of case law reveals that most courts have evaluated medical necessity based on whether or not services provided were in accord with the generally accepted medical practices. Therefore, to prove that the services were not medically necessary, at a minimum, lack of necessity must

be supported by competent evidence such as an IME or peer review or other proof which sets forth a factual basis and medical rationale for denying the claim. A peer review report's medical rationale is insufficient if it is unsupported by or controverted by evidence of medical standards (*see Nir v. Allstate Insurance Company* 7 Misc3d 544).

Upon a showing of lack of medical necessity through a peer review, an Applicant is required to rebut same (*see A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co.,* 16 Misc.3d 131(A).

The peer notes that Assignor was the restrained front-seat passenger in a vehicle involved in a head on collision injuring his neck, mid-back, and lower back. The initial evaluation report dated June 17, 2021 by Vadim Abramov, M.D. notes Assignor complained of neck pain radiating to the left upper extremity. Examination of the cervical spine revealed tenderness and range of motion was decreased. Diagnosis was cervical spine myofascial derangement. An MRI of the cervical spine was ordered. The peer sets forth the extensive findings reported on the cervical spine MRI. Follow up examination report dated July 22, 2021 by Dr. Abramov reported the same findings as initially reported. Initial evaluation report dated February 28, 2022 by Angel Macagno, M.D. documented neck pain, tenderness and bilateral spasms with decreased range of motion. On June 20, 2022, Assignor underwent anterior cervical discectomy and associated surgical services by Dr. Macagno.

The peer states that the standard of care for cervical spine injury for patients with spinal stenosis and degenerative disc disease initiates with clinical findings and imaging in adjunct non-operative interventions/conservative treatments, like medications, manual therapy, PT, chiropractic treatment and acupuncture. ESI is considered for severe cases with the goal of avoiding surgery. Failure of non-operative treatments for more than 3 months are followed by simple discectomy alone. The peer states that Assignor was not evaluated for the complaints of the cervical spine from July 22, 2021 to February 28, 2022. The subjective and objective complaints were unknown during this time period. The progression and worsening of the symptoms were unknown for 7 months. Therefore, the peer states the causal relationship between the cervical spine complaints and the accident was not supported. Therefore, the cervical spine surgery on June 20, 2022 was not medically necessary. As the surgery was not medically necessary all associated services, including intraoperative neuromonitoring provided in connection with the surgery were not medically necessary.

Respondent's peer review fails to set forth sufficient factual basis and medical rationale to establish lack of medical necessity for the cervical spine surgery and intraoperative neuromonitoring provided in connection with the surgery.Because the peer's opinion is based on lack of information it cannot serve to establish lack of medical necessity where, as in this case, there is no evidence that Respondent sought to obtain such missing information by means of a request pursuant to the verification procedures (see A.B. Medical Services PLLC v. American Manufacturers Mut. Ins., 6 Misc3d 133A). As for the peer's comment regarding causation, Dr. Macagno's

report dated February 28, 2022 establishes that his cervical spine injury and worsening condition was caused by the accident of record. The peer acknowledges that intraoperative monitoring is commonly used in connection with such surgery. Applicant is entitled to reimbursement.

As regards the appropriate fees for the codes billed, Respondent submits the affidavit of its coder, Noreen McLoughlin. The coder allows code 95938 at $683.79 and allows code 95861 at $316.38. There is no dispute for these codes.

However, Applicant billed code 95941 defined as, "Continuous intraoperative neurophysiology monitoring from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure). Code 95941 is a "by repot" (BR) code.

Respondent's coder allows reimbursement for BR code 95941 by cross-walk to code 95940 to fix the value of code 95941. Code 95940 is defined as, "Continuous intraoperative neurophysiology monitoring, in the operating room one on one monitoring requiring personal attendance each 15 minutes (List separately in addition to code for primary procedure). The coder notes that code 95941 is billed per hour and code 05940 is billed per 15 minutes, and therefore, the coder allows 4 units of code 95940 ay $294.92 ($73.73 x 4= $294.92.

To substantiate the billing Applicant submits the affidavit of its coder, Priri Kumar, CPC. Code 95941 requires the monitoring of neurophysiological data that is collected from the operating room continuously on-line in real time via secure link. There is no dispute that highly trained and educated personnel are essential to the successful use of intra-operative neurophysiological monitoring. Real time viewing of data and real-time communication with the technologist, surgeon and anesthesiologist is maintained throughout the procedure. The crosswalk code 95940 suggested by Respondent's coder is for one-on-one monitoring while in the operating room. There are no similarities in the procedures. Respondent's coder has failed to consider the compensatory ramifications of applicant's on-line communications in real time not only with the surgeon but also the interpreting neurologist who is also linked. The cross-walk was improper. Respondent's coder did not factor in the costs to Applicant in providing this remote monitoring including salaries for interpreting physicians and technicians and managers justifying the fee in the amount of $4,581.70 which is a fair and reasonable amount for BR code 95941 which was properly billed.

Respondent's coder's argument that the services most closely related to this treatment is code 95940 lacks factual basis. Applicant's coder analysis and reasoning is more persuasive than that of Respondent's coder. Applicant's coder's affidavit is supported by more factual basis. Respondent's coder's affidavit is not sufficient to support a code change and reduction of fees.

Accordingly, Applicant's request for reimbursement is granted.

5. Optional imposition of administrative costs on Applicant.
   Applicable for arbitration requests filed on and after March 1, 2002.

   I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**
   - ☐ The policy was not in force on the date of the accident
   - ☐ The applicant was excluded under policy conditions or exclusions
   - ☐ The applicant violated policy conditions, resulting in exclusion from coverage
   - ☐ The applicant was not an "eligible injured person"
   - ☐ The conditions for MVAIC eligibility were not met
   - ☐ The injured person was not a "qualified person" (under the MVAIC)
   - ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
   - ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the applicant is AWARDED the following:

A.

| **Medical** | | **From/To** | **Claim Amount** | **Amount Amended** | **Status** |
|---|---|---|---|---|---|
| | **New York Medical Monitoring PC** | **06/20/22 - 06/20/22** | **$22,448.69** | **$5,581.87** | **Awarded: $5,581.87** |
| **Total** | | | **$22,448.69** | | **Awarded: $5,581.87** |

B. The insurer shall also compute and pay the applicant interest set forth below. 11/16/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   In accordance with 11 NYCRR 65-3.9(c) interest shall be paid on the clama awarded in the amount of $5,581.87 from November 16, 2022 the date the arbitration requst was received by the AAA.

C. Attorney's Fees

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

In accordane with 11 NYCRR 65-4.6(d) the insurer shall pay Applicant an attorney's fee on the claim awarded in the amount of $5,581.87.

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 New York

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

11/18/2023
(Dated)

Cathryn Ann Cohen

**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:**
7a3db6048ea675237fbbfd04cb21f7d8

**Electronically Signed**

Your name: Cathryn Ann Cohen
Signed on: 11/18/2023