

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Rockaways ASC Development LLC d/b/a  
ASC of Rockaway Beach  
(Applicant)

- and -

Enterprise Rent A Car  
(Respondent)

AAA Case No.	17-23-1321-3163
Applicant's File No.	n/a
Insurer's Claim File No.	18765951
NAIC No.	Self-Insured

**ARBITRATION AWARD**

I, Evelina Miller, 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: JAT

1. Hearing(s) held on 07/09/2024  
Declared closed by the arbitrator on 07/24/2024

Robert Cippitelli Esq from Jakubowitz Law Firm PC participated virtually for the Applicant

Raymon Mak from McCormack, Mattei & Holler participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$16,485.21**, 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 dispute arises from the underlying automobile accident of August 27, 2022, in which the Assignor (JAT), a 55-year-old-male was involved. Thereafter, Assignor sought private medical attention and was eventually evaluated with complaints of pain in the neck, mid and lower back. Patient was then recommended to undergo cervical discectomy which was performed on 4/23/23. The bill in dispute is for cervical discectomy and the associated services performed on 4/23/23. Respondent denied Applicant's bill for date of service of 4/23/23 based on the peer review by Dr. Jeffry Beer M.D., performed on 6/8/23. Respondent also contends that Applicant billed for services in excess of the fee schedule.

The issue presented at the hearing is whether Respondent made out a prima facie case of lack of medical necessity, and if so, whether Applicant rebutted it.

The second issue presented at the hearing is whether Respondent was able to establish its burden in coming forward with competent evidentiary proof to support its fee schedule defenses

#### 4. Findings, Conclusions, and Basis Therefor

I have reviewed the submissions contained in MODRIA which are maintained by the American Arbitration Association. These submissions are the record in this case. My decision is based on my review of that file, as well as the arguments of the parties at the hearing. All the parties at this hearing appeared via ZOOM.

I find that Applicant establishes its prima facie showing of entitlement to recover first-party no-fault benefits by submitting evidentiary proof that the prescribed statutory billing forms, setting forth the fact and 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 Co.*, 5 A.D.3d 742, (2d Dept., 2004). Once an applicant establishes a prima facie case, the burden then shifts to the insurer to prove its defense. See *Citywide Social Work & Psy. Serv. P.L.L.C v. Travelers Indemnity Co.*, 3 Misc. 3d 608, 2004, NY Slip Op 24034 [Civ. Ct., Kings County 2004]).

#### **Medical Necessity:**

Respondent denied Applicant's bill for date of service of 4/23/23 based on the peer review by Dr. Jeffry Beer M.D., performed on 6/8/23.

On June 8, 2023, Dr. Jeffrey Beer M.D., performed a peer review on behalf of Respondent regarding the medical necessity of cervical discectomy and the associated services performed on the patient on 4/23/23. Dr. Beer reviewed medical records of the Assignor and concluded that based on Assignor's medical history as well as recognized medical guidelines, medical necessity for the surgery has not been established.

Dr. Beer reviewed the medical history of the patient and noted that the standard of care for the injuries sustained here is conservative care. He then cited to medical literature which noted that there is no benefit to the minimally invasive discectomy performed here. Patient underwent an MRI in this case that revealed multiple disc herniation without evidence of nerve compression to necessitate the use of a discectomy. Consequently, the procedure under review is not considered medically necessary.

Furthermore, percutaneous discectomy is not recommended because proof of its effectiveness has not been demonstrated.

Regarding discography, Dr. Beer stated that it does not determine diagnosis of radiculopathy. Discography may be justified if the decision has already been made to do a spinal fusion, and a negative discogram could rule out the need for fusion on that disc (but a positive discogram in itself would not indicate fusion). Discography may cause disc degeneration. Given that discography has not proven to be an effective tool in the pre-operative evaluation of patients undergoing surgery, 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 non-pathological disc levels.

Treatment notes did not indicate that there was a neurological deficit which needed further diagnostic evaluation, as such the standard of care was not met in this case. There was no reported increase in neurological symptomatology in the records reviewed.

Once Respondent submits an IME report or peer review that has a sufficient factual basis and medical rationale, then the courts have routinely found that Respondent has established its prima facie defense that the disputed medical service is medically unnecessary. *A Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co.*, 16 Misc.3d 131(A), 841 N.Y.S.2d 824 (Table, Text in WESTLAW), Unreported Disposition, 2007 WL 1989432, 2007 N.Y. Slip Op. 51342(U) (N.Y. Sup. App. Term Jul 03, 2007). See also, *Amaze Medical Supply Inc. v. Eagle Insurance Company*, 2003NY Slip Op 51701 (U), 2 Misc.3d. 128 (App. Term 2d & 11 Dist.-2003).

In order for an applicant to prove that the disputed expense was medically necessary, it must meaningfully refer to, or rebut, the conclusions set forth in the peer review. *High Quality Medical, P.C. v. Mercury Ins. Co.*, 2010 N.Y. Slip Op. 50447(U) (App Term 2d, 11th & 13th Dists. Mar. 10, 2010); *Pan Chiropractic, P.C. v. Mercury Ins. Co.*, 24 Misc.3d 136(A), 2009 N.Y. Slip Op. 51495(U) (App Term 2d, 11th & 13th Dists. July 9, 2009).

### **Rebuttal by Applicant**

Applicant submits a rebuttal by Dr. Joseph Jimenez M.D.. Dr. Jimenez reviewed the patient's medical history and concluded that based on the findings the discectomy was warranted. He stated that Dr. Beer has conveniently untended that the examination findings included tenderness, trigger points, positive orthopedic tests, restricted and painful ROM, decreased muscle strength; and MRI findings included multilevel disc herniations and spinal stenosis. He cited to medical literature which stated that Anterior cervical discectomy and fusion is generally indicated in patients with spondylosis or disc herniation of the cervical spine with myelopathy/radiculopathy that is unresponsive to conservative therapy. Furthermore, it may also be indicated in certain malignant, traumatic, or infective processes of the cervical vertebrae which result in instability.

Thus, as per this guideline, a standard protocol was followed before proceeding to the cervical surgery as well as medical examination revealed constant pain in the cervical spine; positive objective findings and diagnostic studies; and the patient has undergone conservative treatment including physical therapy, and chiropractic treatments with temporary partial relief of pain symptoms, which warranted the performance of the cervical spine surgery. Besides, the cervical discectomy procedure is as effective and this procedure has a much more rapid recovery, and can be an equally effective treatment. Therefore, the above denial statements will not sustain at all.

Further, Dr. Beer opined that "it should be noted that although not binding in these no-fault insurance cases, the 2014 New York State Worker's Compensation Medical Treatment Guidelines do not allow the use of percutaneous discectomy for any reason given the lack of scientific validation." Regarding this statement, it should be noted that the New York State Worker's Board Compensation Guidelines are not at all followed by No-Fault and these are not general guidelines in medical community. Furthermore, according to the Agency for Healthcare Research and Quality Federal Guidelines Database by the U.S. Department of Health and Human Services' statement, the "Work Loss Data Institute (WLDI) is an independent database development company focused on workplace health and productivity." It is always up to the treating physician to adjust and prescribe treatment based on his or her medical judgment as applied to the particular patient being treated. A one size fits all approach to patient care based on general statistics would be entirely against medical treatment principles. The surgery was necessary because of the severity of the injuries and the amount of time that passed with this patient experiencing debilitating cervical spine pathologies despite conservative care. Therefore, the denial of service based on this citation does not stand strong.

### **Conclusion:**

After reviewing all the evidence submitted, as well as considering the arguments presented at the hearing I find the following. Initially, I find that Respondent reached its burden of establishing prima facie defense that the services at issue were not medically necessary.

The crux of Dr. Beer's peer review report is that MRI findings did not warrant the discectomy performed here. The standard of care was not followed as the standard of care is conservative treatment. Additionally, he cited medical literature which determined that there is no efficacy of the discectomy performed in this case. Applicant submits a rebuttal by Dr. Jimenez who discussed the medical history of the patient and determined that based on the clinical findings the discectomy was warranted. He went on to say that the patient had undergone extensive conservative therapy which did not resolve the patient's clinical presentation. Based on the above, I find that Applicant has rebutted the findings of the peer review doctor. I find Applicant's evidence to be more persuasive.

Accordingly, Applicant's claim for reimbursement is granted.

Respondent also argued that Applicant billed for services in excess of the fee schedule. Respondent submits a coder affidavit in support of its fee schedule reduction. At the time of the hearing Applicant objected to the fee coder submitted by the Respondent since it was uploaded by the Respondent just 6 days prior to the hearing date. This arbitrator allowed Applicant to upload a rebuttal to Respondent's fee coder's affidavit which was uploaded late.

**Fee Schedule:**

The rates charged by Applicant must be in accordance with Insurance Law § 5108, as the charges for services rendered "shall not exceed the charges permissible under the schedules prepared and established by the chairman of the Workers Compensation Board for Industrial Accidents, except where the insurer or arbitrator determines that unusual procedures or unique circumstances justify the excess charge."

In addition, § 5108 (c) states that, "no provider of health services... may demand or request any payment in addition to the charges authorized pursuant to this section."

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). 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).

Effective April 1, 2013, 11 NYCRR 65-3.8(g)(1) has been amended so that the application of the New York State Worker's Compensation fee schedule is no longer a precludable defense and no payment is due on those claims in excess of the fee schedule. Per 11 NYCRR 65-3.8(g), where the services were rendered after April 1, 2013, a defense of excessive fees is not subject to preclusion Surgicare Surgical Associates v. National Interstate Ins. Co., Misc.3d, N.Y.S.3d, 2015 N.Y. Slip Op. 25338 (App. Term 1st Dept. Oct. 8, 2015), aff'g, 46 Misc.3d 736, 997 N.Y.S.2d 296 (Civ. Ct. Bronx Co. 2014) (New Jersey fee schedule). The insurer is entitled to reduce the bills to the proper fee schedule amount.

Respondent submits a fee coder's affidavit by Jeffrey Futoran CPC who determined that the appropriate rate of reimbursement per the EAPG is \$6,402.03 for the facility fees associated with cervical discectomy at issue in this case.

Regarding modifier 59 billed by Applicant, Mr. Futoran stated that it was inappropriately added on. He stated:

*"Section 2.6 of the APG Provider Manual states:*

*CPT Modifier 59 (Separate Procedures or Distinct Procedural Service): CPT Modifier 59 should be used to designate instances when distinct and separate multiple services with the same APG are provided to the patient on a single date of service (eg. separate encounters, different surgeries, different sites or organ systems, separate incisions). Modifier 59 may also be used to report those procedures/services considered a component of another procedure, when the service is carried out independently or considered unrelated or distinct from the other procedures/services provided at the same time. Normally when multiple procedures map to the same APG, the additional occurrences (beyond the first) will consolidate (i.e., no payment at the line level). However, when Modifier 59 is used, the additional same APG procedures will pay at 50% of the amount paid for the first procedure.)*

*Assignee's operative report documents procedures reported under CPT codes 63075, 63076-59, 22526-59 and 22527-59 were rendered, during the same encounter / surgery, by the same surgeon and at the same site / location (C5-C6 and C6-C7 levels of the spine).*

*It should be noted CPT 63076 and 22527 are known as "add-on-codes" and can only be reported with their related primary codes (63075 and 22526).*

*The instructions of the AMA CPT Book state:*

*Add-on Codes*

*Some of the listed procedures are commonly carried out in addition to the primary procedure performed. These additional or supplemental procedures are designated as add-on codes with the + symbol and they are listed in Appendix D of the CPT codebook. Add-on codes in CPT 2023 can be readily identified by specific descriptor nomenclature that includes phrases such as "each additional" or "(List separately in addition to primary procedure)."*

*The add-on code concept in CPT 2023 applies only to add-on procedures or services performed by the same physician. Add-on codes describe additional intra-service work associated with the primary procedure, eg, additional digit(s), lesion(s), neurorrhaphy(s), vertebral segment(s), tendon(s), joint(s).*

*Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. All add-on codes in the CPT code set are exempt from the multiple procedure concept (see the modifier 51 definition in Appendix A).*

*As stated above, add-on-codes describe additional intra-service work associated with the primary procedure.*

*Per the above AMA reporting rules, add-on-code 63076 and 22527:*

- a. may never be reported as a stand-alone code and*
- b. the procedure is deemed additional intra-service work associated with primary procedure (63075 and 22527).*

*Per the instructions of the AMA CPT book Applicant has rendered a primary procedure and intra-service work association with a primary procedure*

*As these procedures cannot be independently reported, modifier 59 may not be used.*

*Per the above analysis, assignee has improperly appended modifier 59 to CPT 22526, 22527 and 63076.*

*Pursuant to the above analysis modifier 59 was omitted when entering the codes into the 3M Grouper software systems."*

Using the 3M Software, Mr. Futoran determined that the appropriate rate of reimbursement here is \$6,402.03. I reviewed the fee coder affidavit by Mr. Futoran and find it credible and persuasive. As such, I find that Respondent reached its 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. Supra.

In rebuttal Applicant submits a coder affidavit by Roza Vinogradov CPC.. She refers to surgical note which stated the following:

"C5-6 disc level was accessed by incision with discogram (62291-59 and 72285-59), decompression of the nervous system (63075), followed by excising equipment and incision bipolar instrumentation to cauterize the annulus which involves the musculoskeletal system (22526-59). The note shows a repeat at C6-7 (6376-59 and 22527-59)."

Ms. Vinogradov went on to say that Mr. Futoran ignores NYS WCB 2021 FAQ6 which specifically provides that "additional procedure codes and add-on codes" for these services "will be reimbursed in accordance with EAPG methodology." If it were as he claimed the only one code is allowed, then it would state the additional procedures and add-on codes "will not be reimbursed in accordance with EAPG methodology."

"Would additional procedure codes and add-on codes be allowed?

Medical necessity and appropriate procedure performed during the same surgical session will be reimbursed in accordance with EAPG methodology."

For purposes here DoH Guidelines provide modifiers can turn off consolidation to allow for discounted payments at 50% of the amount paid for a first procedure and specifically included circumstances here for suing modifier 59 on 22526.

Ms. Vinogradov then discussed NCCI edits and pointed out that the codes billed here were add-on codes which have not been precluded by NCCI edits from being billed together. She concludes by stating that the codes billed here are not subject to consolidation but rather to 505 discount based on the multiple procedure rule.

Ms. Vinogradov cites to numerous IHC reports which agree with her assessment of the proper rate of reimbursement for CPT codes 22526/22527 and 63075. She concludes by stating that Applicant is entitled to reimbursement in the amount of \$14,773.93.

Upon my review of the evidence submitted and the arguments presented at the hearing, I find Respondent's coder affidavit to be more persuasive. MS. Vinogradov cites to numerous IHC reports which do not address the specific surgery performed here. None of the IHC providers had the opportunity to review Applicant's Op-Report to determine whether the procedures performed here qualify to have modifier 59 attached them for the purpose of billing. Some of the IHC reports address CPT code 62287 which was not even billed by Applicant here.

Additionally, nowhere is the operative report discussed here to determine whether the procedure performed here was distinct and separate. Simply because Applicant billed certain codes with modifier 59, does not make it proper.

As such, I find that Applicant is entitled to reimbursement in the amount of \$6,402.03 as determined by Respondent's coder.

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
	<b>Rockaways ASC Development LLC d/b/a ASC of Rockaway Beach</b>	<b>04/23/23 - 04/23/23</b>	<b>\$16,485.2 1</b>	<b>Awarded: \$6,402.03</b>
<b>Total</b>			<b>\$16,485.2 1</b>	<b>Awarded: \$6,402.03</b>

- B. The insurer shall also compute and pay the applicant interest set forth below. 10/17/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Since the motor vehicle accident occurred after April 5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. 11 NYCRR 65-3.9(a). In accordance with 11 NYCRR 65-3.9c, interest shall be paid on the claims totaling \$6,402.03 from the date the arbitration was commenced.

C. Attorney's Fees

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

Respondent shall pay Applicant an attorney's fee upon the amount awarded plus the interest, as calculated in section "B" above, and in accordance with 11 NYCRR 65-4.6(e), i.e., 20 percent of the amount of first party benefits, plus interest thereon. The minimum attorney's fee payable shall be in accordance with 11 NYCRR 65-4.6c. For cases filed after February 4, 2015, there is no minimum attorney's fee but there is a maximum fee of \$1,360.00. However, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b)."

- 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 Kings

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

09/03/2024  
(Dated)

Evelina Miller

### **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:**  
0efd1bb54d9bc3aff9734324ae2be871

### **Electronically Signed**

Your name: Evelina Miller  
Signed on: 09/03/2024