

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Ahmed Elfiky MD d/b/a Sinai Medical
Associates PC
(Applicant)

- and -

Progressive Casualty Insurance Company
(Respondent)

AAA Case No.	17-24-1345-7371
Applicant's File No.	3130679
Insurer's Claim File No.	23-7517118
NAIC No.	24260

ARBITRATION AWARD

I, Preeti Priya, 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 [ED]

1. Hearing(s) held on 09/03/2024
Declared closed by the arbitrator on 09/03/2024

Melissa Scotti, Esq., from Law Offices of Andrew J. Costella Jr., Esq. participated virtually for the Applicant

Jean Schabhuttl, from Progressive Casualty Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$3,874.98**, 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 July 12, 2023, in which the Assignor, a 51 year old female, was a driver. The issues in this matter are:

Whether Applicant established entitlement to No-Fault compensation for an office visit and shockwave provided to Assignor;

Whether Respondent made out a prima facie case of lack of medical necessity and, if so, whether Applicant rebutted it.

Whether Respondent established that Applicant billed in excess of the New York Workers' Compensation Schedule.

4. Findings, Conclusions, and Basis Therefor

At the hearing held virtually via Zoom, Applicant was represented by Melissa Scotti, Esq., who presented oral arguments and relied upon documentary submission at the hearing. Jean Schabhtl, appearing for Respondent, presented oral arguments and relied upon documentary submissions. I have reviewed the submission contained in the American Arbitration Association's ADR Center. These submissions are the record in this case.

Assignor was evaluated at Four Square Physical Therapy PC on July 28, 2023. She received conservative care including physical therapy. She also underwent diagnostic testing. Of significance to this matter is that on October 31, 2023, an office visit was provided. Between November 1, 2023 and January 17, 2024, shockwave was provided to Assignor. Applicant submitted the claims for the office visit and shockwave to Respondent; payment was denied. Respondent's representative, stated at the hearing that Respondent concedes that Applicant is entitled to \$206.32.

After reviewing the records, I find that Applicant established its prima facie case of entitlement to No-Fault compensation. See Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). Since Respondent's denials were timely, it was within its rights to assert that further treatment was medically unnecessary. Liberty Queens Medical, P.C. v. Liberty Mutual Insurance Co., 2002 NY Slip Op 40420(U), 2002 WL 31108069 (App. Term 2d & 11th Dists. June 27, 2002); Country-Wide Insurance Co. v. Zablocki, 257 A.D.2d 506, 684 N.Y.S.2d 229 (1st Dept. 1999).

On October 27, 2023, William Walsh, MD, conducted an independent medical examination. Thereafter, no fault benefits were terminated effective November 8, 2023. Dr. Walsh reviewed medical records including evaluation reports, progress notes and diagnostic test results. After conducting a physical examination, Dr. Walsh opined that further treatment was not medically necessary.

An IME doctor must establish a factual basis and medical rationale for his asserted lack of medical necessity of further health care services. Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), 2008 NY Slip Op 51863(U), 2008 WL 4222084 (App. Term 2d & 11th Dists. Sept. 3, 2008). If he does so, it becomes incumbent on the claimant to rebut the IME review, see AJS Chiropractic, P.C. v. Mercury Ins. Co., 22 Misc.3d 133(A), 2009 NY Slip Op 50208(U), 2009 WL 323421 (App. Term 2d & 11th Dist. Feb. 9, 2002), because the ultimate burden of proof on the issue of medical necessity lies with the claimant. See Insurance Law § 5102; Shtarkman v. Allstate Insurance Co., 2002 NY Slip Op 50568(U), 2002 WL 32001277 (App. Term 9th & 10th Jud. Dists. 2002) (burden of establishing whether a medical test performed by a medical provider was medically necessary is on the latter, not the insurance

company). The insured or the provider bears the burden of persuasion on the question of medical necessity. Bedford Park Medical Practice P.C. v. American Transit Ins. Co., 8 Misc.3d 1025(A), 806 N.Y.S.2d 443 (Table), 2005 NY Slip Op. 51282(U), 2005 WL 1936346 (Civ. Ct. Kings Co., Jack M. Battaglia, J., Aug. 12, 2005). This burden of proof is properly placed on a claimant health care provider because presumably it is in possession of the injured party's medical records.

Assignor submitted a Rebuttal by Ahmed Elfiky, MD, addressing the IME report and in support of the shockwave. He set forth Assignor's complaints, medical findings and treatment. He stated "the patient's (+) objective MRI & EMG testing revealed undisputed evidence of multilevel cervical and lumbar spine disc herniations impinging the ventral thecal sac,. a partial tear of the central portion of the TFCC of the right wrist, as well as medial meniscus partial tear of the right knee." He noted "medical re-examination findings from Nov. 1, 2023 - performed less than a week following Dr. Walsh's IME - recorded [Assignor's] limp on ambulation and chief complaints of right shoulder pain, right knee pain and swelling, neck and low back pain radiating into the bilateral hips and shoulders associated with tingling sensations, as well as several positive objective clinical exam and test findings. Said (+) findings included the following: diminished sensation including hyposthesia in the right CS, C6 & LS dermatomal distribution, limited ranges of motion in the cervical spine associated with paravertebral muscle spasms from C2 - C7, difficulty elevating the right arm over 125 degrees, weakness (4+/5) of the right deltoid, bicep and triceps, positive SLR Testing bilaterally associated with paravertebral muscle spasms from LI-SI, as well as weakness (4+/5) on right hip flexion/extension and leg extension, as well as significantly restricted ranges of motion in all planes of the cervical and lumbar spine with quantified measurements."

Applicant submitted contemporaneous reports which do rebut the IME examination and report. I find Dr. Elfiky's rebuttal detailed and sufficient to rebut the findings and conclusions of Dr. Walsh. It is clear from the Rebuttal and the medical records that Assignor medically needed further treatment post IME. Applicant has rebutted Respondent's defense and has sustained Applicant's burden of proof by a preponderance of credible evidence.

The rates charged by Applicant must be in accordance with Insurance Law § 5108. The services in dispute were performed subsequent to the effective date, April 1, 2013, of the Fourth Amendment to Regulation 68-C. Sub division (g) (1) of No-Fault Regulation 65-3 now states that proof of fact that the amount of loss sustained pursuant to Insurance Law section 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for claimed medical services under any circumstances: (i) when the claimed medical services were not provided to an injured party; or (ii) for those claimed medical services that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers.

I take judicial notice of the New York State Workers' Compensation fee schedule. See Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 20 (2d Dept. 2009); LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), 2011 NY Slip Op

51721(U) (App Term 2d, 11th & 13th Jud Dists. 2011); Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A), 2011 NY Slip Op 50040(U) (App Term, 1st Dept. 2011).

I note, effective April 1, 2013 11 NYCRR 65-3(g)(1) had been amended and the no-fault regulations now read, "proof of fact and amount of loss sustained pursuant to insurance law §5106 (A) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances:

- (i) when the claim medical services were not provided to an injured party; or
- (ii) for those claim medical service fees that exceed the charges permissible pursuant to insurance law §5108 (A) and (B) in the regulations promulgated there under the services rendered by medical providers. (2) This subdivision shall apply to medical services rendered on or after April 1, 2013.

The date of service falls within the amended regulations.

Respondent relies upon an affidavit by Karen McCauley, a Certified Medical Coder employed by Progressive Casualty Insurance Company. Respondent met its burden to come forward with competent evidentiary proof to support its fee schedule defense Robert Physical Therapy, P.C. v. State Farm Mut. Ins. Co., 13 Misc 3d 172 (Civ.Ct. Kings Co.2006).

She has worked with the New York State Workers' Compensation Fee Schedule for over four years." and has "been a certified medical coder by the American Academy of Professional Coders ("AAPC")." She stated "The CPT book is a listing of descriptive terms and identifying codes for reporting medical services and procedures provided to patients. The CPT book provider's further explanation of descriptive terms and identifying codes. When more clarification is needed the CPT book directs a coder to the Current Procedural Terminology Assistant (CPT Assistant) which is also authored by the AMA. The CPT Assistant provides even greater clarity than the CPT book on specific coding issues."

She then explained each of the codes used by Applicant. She set forth her calculations and stated "0101T is listed in the NYS Workers' Compensation Fee Schedule [fee schedule] and CPT as a Category III Code. According to the NYS Workers' Compensation Fee Schedule Effective 4/1/2019 Category III codes represent new and emerging technology and should be reported when available." She stated "Based on the code definition of 0101T and the example above, extracorporeal shock wave involving musculoskeletal system (0101T) should not be billed more than once per date of service."

She highlighted "Further support is found with Centers for Medicare/Medicaid Services (CMS); they also indicate that procedure code O101T would be allowed once per date of service. A Medical Unlikely Edit (MUE) for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. Procedure code O101T has a Practitioner Services MUE

Value of 1. Based on the CPT code description and the MUE value code O101T would be payable once per date of service."

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 Medical, P.C. v. Mercury Casualty Co., 24 Misc.3d 58, 884 N.Y.S.2d 558 (App. Term 2d, 11th & 13th Dists. 2009). Applicant relies upon an affidavit Hank Ross, MD.

He stated "the Respondent has failed to proffer an affidavit from a certified fee coder CONCERNING THE INSTANT ARBITRATION MATTER; instead, the Respondent has uploaded a generic affidavit dated 4/03/2022 which not only FAILS to address this particular Assignor and/or her specific shockwave therapy claims, but also said template affidavit was crafted PRIOR to the Assignor's motor vehicle accident of 7/12/2023. Based upon this alone, Respondent's affidavit is both defective and meaningless." He continued with "the Respondent's misguided and speculative contention that "Since code 0 IO IT is not defined as per initial or each additional (site/level, body part) it is allowable one time per date of service" is incorrect and mere conjecture! In fact, the Respondent's coder's fugazy argument has been recently debunked pursuant to the learned Arbitrator Rosenberger's recent AAA award clearly holding in pertinent part, as follows: "To assert the testing would apply to the entire musculoskeletal system would mean the provider could only bill once even if he treated every bone, muscle or joint in the body as that is what makes up the entire system. 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."

He explained, "Category III code 0101T is indeed reportable for treatment of the musculoskeletal system. Moreover, it does not identify a specific treatment time or anatomic location; therefore, more than one unit of this code is reportable per procedure. Additionally, this service is reportable and reimbursable as this code would be properly reported for each and every ESWT performed on any number of components of the musculoskeletal system. The CPT Code Book instructs that 0101T is EXTRACORPOREAL SHOCK WAVE INVOLVING MUSCULOSKELETAL SYSTEM, NOT OTHERWISE SPECIFIED, therefore allowing for more than one unit of this code, in the amount of \$700.39 per each region of the spine, i.e. cervical spine and/or lumbar spine. Simply stated, shockwave therapy is not limited to reimbursement of only once per day for the entire musculoskeletal system. Incidentally - and never addressed by the Respondent's lockstep employee - is that the "CPT Electronic Inquiry# 13736" issued by the AMA notes that it is appropriate to bill for different anatomic regions when reporting code 0101T. Furthermore, our patient's shockwave therapy was performed on the EIP's extremities and spine."

In reviewing the Affidavits and evidence submitted, I am persuaded by Ms. McCauley as she is clear and succinct in her analysis. The significant difference between the certified coders and what ultimately persuades me in Respondent's favor is Ms. McCauley explains the description for CPT code 0101T is "Extracorporeal shock wave

involving musculoskeletal system, not otherwise specified, high energy". As per the description, this code can only be billed once since it involves the entire musculoskeletal system. If the intent is for this code to be billed in multiple units, the description would have indicated "each area". She also gives examples of Category III codes that can be billed with multiple units. Further, Dr. Ross' Affidavit does not list any credentialing by any entity. He states that he employs licensed certified fee coders with decades of experience and training specializing in orthopedic CPT, HCPCS, ICD9 and ICD10 coding." I find that Applicant would only be entitled to \$700.39 per date of service based upon the Fee Schedule and the professional coder's Affidavit.

Applicant is awarded \$3,174.59.

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
	Ahmed Elfiky MD d/b/a Sinai Medical Associates PC	10/31/23 - 01/17/24	\$3,874.98	Awarded: \$3,174.59
Total			\$3,874.98	Awarded: \$3,174.59

- B. The insurer shall also compute and pay the applicant interest set forth below. 04/29/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant's award shall bear interest at a rate of two percent per month, calculated on a pro rata basis using a 30-day month from the date payment became overdue to the date of the payment of the award pursuant to 11 NYCRR 65-3.9 (a). The end date for the calculation of the period of interest shall be the date of payment of the claim. General Construction Law § 20 ("The day from which any specified period of time is reckoned shall be excluded in making the reckoning.")

C. Attorney's Fees

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

Respondent shall pay Applicant a separate attorney's fee, in accordance with 11 NYCRR 65-4.6(d). Since the within arbitration request was filed on or 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 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 NY

SS :

County of New York

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

09/10/2024
(Dated)

Preeti Priya

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:
ab49a300b440fef0d798e46f474786ec

Electronically Signed

Your name: Preeti Priya
Signed on: 09/10/2024