

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Alexandre DeMoura M.D. PC dba New York Spine Institute (Applicant)	AAA Case No.	17-24-1363-0574
	Applicant's File No.	3318716
	Insurer's Claim File No.	01007286515-01
- and -	NAIC No.	37648

Permanent General Assurance Corp of OH
(Respondent)

ARBITRATION AWARD

I, Fred Lutzen, 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 or "Assignor"

1. Hearing(s) held on 03/26/2025
Declared closed by the arbitrator on 03/26/2025

Ryan Berry, Esq., from Israel Purdy, LLP participated virtually for the Applicant

Scott Schwaber, Esq., from Freiberg, Peck and Kang, LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$15,784.50**, 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 male EIP (first initial "D") was 32-years-old when he was injured as the driver in an automobile accident on 2/22/2024. He subsequently underwent cervical ACDF surgery at C4-C5 on 7/16/2024. Applicant seeks reimbursement of \$15,784.50 for performing this procedure on 7/16/2024, as well as an office visit one day earlier on 7/15/2024.

Respondent denied reimbursement asserting a lack of medical necessity defense based on an orthopedic examination [IME] performed by Dr. Howard Levy, M.D., on 6/4/2024. Respondent also raised fee schedule defenses.

The issues to be determined are (1) whether the post-IME treatment and services were medically necessary and, if so (2) whether the charges are within fee schedule allowances.

4. Findings, Conclusions, and Basis Therefor

This case was decided based on prevailing law, the submissions of the parties as contained in the electronic file ["MODRIA"] maintained by the American Arbitration Association, and the oral arguments of the parties' representatives at hearing. There were no live witnesses.

Unless the parties' agreement provides otherwise, arbitrators need not apply the rules of evidence, are not bound by principles of substantive law, may do justice as they see it, and may apply his own sense of law and equity to the facts as he finds them to be. Matter of New Century Acupuncture, P.C. v. Country Wide Ins. Co., 48 Misc.3d 1201(A), 18 N.Y.S.3d 580 (Table), 2015 N.Y. Slip Op. 50919(U) at 2, 2015 WL 3821534 (Dist. Ct. Suffolk Co., C. Stephen Hackeling, J., June 18, 2015); see also, *Rules for Arbitration of No-Fault Disputes in the State of New York*; Effective August 16, 2013, [p](1), "The arbitrator shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to legal rules of evidence shall not be necessary." <https://nysinsurance.adr.org>.

Medical Necessity

Respondent has the burden to first demonstrate, prima facie, that the services lacked medical necessity. An insurer may rely on an IME that the injured person has reached the status quo, shifting the burden to the claimant to demonstrate by a preponderance of the credible evidence that the treatment at issue was medically necessary. Amato v. State Farm Ins. Co., 40 Misc.3d 129(A), 975 N.Y.S.2d 364 (Table), 2013 N.Y. Slip Op. 51113(U), 2013 WL 3497906 (App. Term 9th & 10th Dists. July 3, 2013), *rev'g*, 30 Misc.3d 238, 910 N.Y.S.2d 637 (Dist. Ct. Nassau Co. 2010).

The IME

On 6/4/2024, Dr. Levy reviewed medical records and examined the EIP. Dr. Levy noted that at the ER it was reported there was a fracture of the left knee, neck pain, and back pain. Neck pain radiated down the arms and hands. At the time of the IME on 6/4/2024, the EIP complained of headaches, neck, mid-back, low-back, and left knee pain.

This claim is related solely to the neck condition.

Examination of the cervical spine revealed minimal tenderness to palpation of the cervical paraspinal musculature. Ranges of motion were normal. Neurological examination was normal/negative. Dr. Levy diagnosed the EIP with resolved cervical spine sprain/strain (and other resolved injuries). Dr. Levy opined, "Based on the history

obtained, the physical examination performed, and the available medical records for my review, there is no need for further physical therapy or orthopedic treatment. The tenderness on the cervical spine, thoracic spine, lumbar spine and left knee is subjective. [¶] From an orthopedic perspective, there is no need for surgery, injections, prescription medication, diagnostic testing, household help or durable medical equipment."

Rebuttal Evidence

Prior to the IME, the EIP was evaluated on 5/20/2024 by Dr. Alexandre B. de Moura, M.D., who reported that the EIP's symptoms remain unchanged following conservative treatment. The EIP reported ongoing "neck pain and bilateral upper extremity pain. He also has associated numbness, tingling and increased weakness specially in digits 1, 2." Dr. Alexandre B. de Moura noted MRI performed on 4/2/2024 revealed "evidence of small central C4-C5 disc herniation..." This was also noted by Dr. Levy.

Dr. Alexandre B. de Moura, M.D. noted the EIP was "in excessive discomfort ... evidence of bilateral paraspinal muscular spasms ... range of motion was painful ... tenderness to palpation." Cervical ranges of motion were recorded with some restrictions, some movements over 50% reduced from normal. Dr. Alexandre B. de Moura, M.D., opined that the EIP was a candidate for cervical spine surgery, with diagnoses including radiculopathy and herniation. Treatment continued.

On 6/17/2024, the EIP returned to Dr. Alexandre B. de Moura, M.D., who reported the EIP was still unchanged with treatment and reported the same examination findings. Dr. Alexandre B. de Moura opined the EIP was a candidate for ACDF at C4-C5, which was scheduled.

The procedure was performed on 7/16/2024.

Further Discussion

I am now tasked with weighing these competing reports to determine which is more persuasive on the issue of medical necessity. I am persuaded by Applicant. An IME does not "conclusively prove that [subsequently performed treatments] were not medically necessary" since "a person's condition can 'wax and wane' after a motor vehicle accident." Huntington Medical Plaza, P.C. v. Travelers Indemnity Co., 43 Misc.3d 129(A), 990 N.Y.S.2d 437 (Table), 2014 N.Y. Slip Op. 50527(U), 2014 WL 1344448 (App. Term 2d, 11th & 13th Dists. Mar. 21, 2014), *aff'g*, 34 Misc.3d 874, 937 N.Y.S.2d 830 (Civ. Ct. Queens Co. 2011).

I find the treating provider's examinations sufficiently persuasive on the issue of medical necessity and conclude that Applicant met its shifted burden regarding the need for further treatment.

Dr. Alexandre B. de Moura's examination findings are sufficiently detailed and simply paint a different clinical picture of this EIP. While not always determinative, the treating physician's opinion is entitled to some deference. Oceanside Medical Healthcare, P.C. v. Progressive Ins., 2002 N.Y. Slip Op. 50188(U) at 5, 2002 WL 1013008 (Civ. Ct. Kings

Co., Jack M. Battaglia, J., May 9, 2002). In this close case, I defer to Applicant and conclude that Applicant met its shifted burden regarding the need for further care and services related to the cervical spine.

Fee Schedule

Pursuant to *11 NYCRR, Section 65-3.16*, Measurement of no-fault benefits, (a) Medical expenses, (1), "Payment for medical expenses shall be in accordance with fee schedules promulgated under section 5108 of the Insurance Law and contained in Part 68 of this Title (Regulation 83).

The Workers' Compensation fee schedule, which is required by law and incorporated by reference into the Insurance Department Regulations, is of such sufficient authenticity and reliability that it may be given judicial notice, and need not be submitted to the court. Z.A. Acupuncture, P.C. v. Geico Ins. Co., 33 Misc.3d 127(A), 939 N.Y.S.2d 745 (Table), 2011 N.Y. Slip Op. 51842(U), 2011 WL 4949646 (App. Term 2d, 11th & 13th Dists. Oct. 11, 2011); Lvov Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), 939 N.Y.S.2d 741 (Table), 2011 N.Y. Slip Op. 51721(U), 2011 WL 4424472 (App. Term 2d, 11th & 13th Dists. Sept. 16, 2011).

As such, I take appropriate evidentiary notice of the NY WC Fee Schedule. If the fees can be determined from a straightforward reading of the fee schedule, no coder affidavit or fee audit is required. Absent a straight-forward calculation confirming the correct rate, 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). This also includes consideration and reference to the CPT Assistant and/or CPT Code Book consistent with the holding in Global Liberty Ins. v. McMahon, 2019 NY Slip Op 03692 (App. Div. 1st Dept. 2019).

Respondent submitted a coding analysis by Lori Ercolini, CPC, dated 11/13/2024. Coder Ercolini reviewed the bills and medical records and determined that the total allowed should be \$12,117.66. [\$1,337.64 + \$10,392.51 + \$299.81 + \$87.70 = \$12,117.66].

The office visit on 7/15/2024 was billed under CPT Code 99214. Coder Ercolini stated, "Bill #1 is billed with code 99214 and the documentation for 7/15/24 indicates that they performed a follow-up office visit. According to the CPT table for E/M codes, the more appropriate code for this visit is 99213. Therefore, Bill #1 will be allowed with code 99213."

The fee schedule describes both codes 99214 and 99213 as an evaluation of "an established patient." The only noticeable difference is that 99214 is for 25 minutes and 99213 is for 15 minutes. Coder Ercolino did not adequately explain why she reduced this code to 99213 given the accompanying report does not indicate the time spent. This defense fails. Applicant is awarded \$127.41 (RVU 8.46 x \$15.06 CF = \$127.41).

For the surgeon's bills for DOS 7/16/2024, Coder Ercolini stated:

Bill #'s 2 and 4 are MD bills for the primary surgeon and Bill #3 is the PA assistant surgeon bill. The op report for 7/16/24 indicates they performed an anterior cervical discectomy, arthrodesis, anterior cervical instrumentation and structural allograft and bone marrow harvesting all on level C4-5. That is 1 cervical level along with arthrodesis on that level, along with instrumentation of 1 vertebral segments and insertion of interbody device and allografts. Since this surgery was performed at one level of C4-5, code 63075 is the correct code for the discectomy. The procedures performed are open procedures and code 76000 is not necessary when performing an open procedure. Therefore, 76000 will be allowed at zero.

Coder Ercolini calculated:

Calculation for Bill #'s 2 - 7/16/24 - MD primary surgeon bill:

RVU's x conversion factor = Fee Schedule Amount

20930 = 1.19×251.94 = \$299.81 - Add-on code.

76000 = N/A = \$0.00 - Not billed for an open procedure.

TOTAL = \$299.81.

Calculation for Bill #4 - 7/16/24 - MD primary surgeon bill:

RVU's x conversion factor = Fee Schedule Amount

22551 = 18.42×251.94 = \$4,640.73

22845 = 12.27×251.94 = \$3,091.30 - Add-on code

22853 = 2.67×251.94 = \$672.68 - Add-on code

63075 = $(14.36 \times 251.94) \times .5$ = 3,617.86 x .5 = \$1,808.93

20939 = 0.71×251.94 = \$178.88 - Add-on code, however, \$178.87 was billed []...

TOTAL = \$10,392.51

For the Assistant's charges, Coder Ercolini stated:

Bill #3 is billed with modifier AS. This bill is from the PA and in NY the correct modifier to indicate a PA assistant at surgery is modifier 83. The pricing for modifier 83 is 10.7% of the fee schedule amount for the code.

When multiple surgical codes are billed together, Ground Rule #5 in the Surgery section of the NY Workers' Compensation Medical Fee Schedule applies. This indicates that the greatest fee is allowed at 100% of the fee schedule amount while the lesser fees are allowed at 50% of the fee schedule amount. That applies unless the code billed is an add-on code. In that case the add-on code is allowed at 100% of the fee schedule amount. A CPT code can be identified as an add-on code if it appears in Appendix D - Summary of CPT Add-on Codes (attached) in the CPT book.

Coder Ercolini calculated:

Calculation for Bill #3 - 7/16/24 - PA assistant surgeon bill:

RVU's x conversion factor = Fee Schedule Amount
 22551-83 = $(18.42 \times 251.94) \times .107 = 4,640.73 \times .107 = \496.56
 22845-83 = $(12.27 \times 251.94) \times .107 = 3,091.30 \times .107 = \330.77 - Add-on code, assistant.
 22853-83 = $(2.67 \times 251.94) \times .107 = 672.68 \times .107 = \71.98 - Add-on code, assistant.
 63075-83 = $(14.36 \times 251.94) \times .107 = 3,617.86 \times .107 = \387.11 - Greatest fee, assistant.
 20939-83 = $(0.71 \times 251.94) \times .107 = 178.88 \times .107 = \19.14 - Add-on, assistant.
 20930-83 = $(1.19 \times 251.94) \times .107 = 299.81 \times .107 = \32.08 - Add-on code, assistant.
 76000-83 = N/A = \$0.00 - Not billed for an open procedure.
 TOTAL = \$1,337.64

After considering the evidence submitted, and taking evidentiary notice of the fee schedule, CPT Assistant, etc., I find Respondent has established that the correct allowance for DOS 7/16/2024 is as Coder Ercolini indicated, i.e., $\$1,337.64 + \$10,392.51 + \$299.81 = \$12,029.96$.

Coder Ercolini's opinion and analysis meets Respondent's burden of proof as to DOS 7/16/2024. Her affidavit constitutes "competent evidentiary proof to support its fee schedule defenses." *See, Robert Physical Therapy PC., supra*. However, with respect to DOS 7/15/2024, defense failed as Respondent did not justify a reduction of code 99214 to 99213. This is allowed at \$127.41.

The total: $\$12,029.96 + \$127.41 = \$12,157.37$.

Conclusion

Having carefully considered the submissions of the parties, the relevant case law, and the arguments of respective counsel, I conclude that the preponderance of the credible evidence supports a finding in favor of Applicant on the issue of medical necessity and, as explained above, a split finding on the fee schedule issues.

Applicant is awarded \$12,157.37.

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
	Alexandre DeMoura M.D. PC dba New York Spine Institute	07/16/24 - 07/16/24	\$13,047.58	Awarded: \$10,692.32
	Alexandre DeMoura M.D. PC dba New York Spine Institute	07/16/24 - 07/16/24	\$2,609.51	Awarded: \$1,337.64
	Alexandre DeMoura M.D. PC dba New York Spine Institute	07/15/24 - 07/15/24	\$127.41	Awarded: \$127.41
Total			\$15,784.50	Awarded: \$12,157.37

- B. The insurer shall also compute and pay the applicant interest set forth below. 08/14/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. *See generally*, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30-day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance

Department regulations." *See*, 11 NYCRR 65-3.9(c); and OGC Op. No. 10-09-05 (interest accrues from date Applicant "*actually requests arbitration*" or commences a lawsuit). The Superintendent and the New York Court of Appeals have interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009).

NOTE: Interest was not tolled for the bills related to DOS 7/16/2024. Applicant commenced arbitration within 30-days of the denials. However, for DOS 7/15/2024, arbitration was filed before the denial was due. The bill was received by Respondent on 8/27/2024 and the denial was not due until 9/26/2024. For DOS 7/15/2024 (\$127.41), interest begins from 9/26/2024.

C. Attorney's Fees

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

Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. *See*, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or the court, subject to a maximum fee of \$1360." *Id.*

- 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 Onondaga

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

04/10/2025

(Dated)

Fred Lutzen

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:
75d6a3e125bf65f1fe7b4e631a4566c0

Electronically Signed

Your name: Fred Lutzen
Signed on: 04/10/2025