AWARD OF DISPUTE RESOLUTION PROFESSIONAL

I, THE UNDERSIGNED DISPUTE RESOLUTION PROFESSIONAL (DRP), designated by the American Arbitration Association under the Rules for the Arbitration of No-Fault Disputes in the State of New Jersey, adopted pursuant to the 1998 New Jersey “Automobile Insurance Cost Reduction Act” as governed by N.J.S.A. 39:6A-5, et. seq., and, I have been duly sworn and have considered such proofs and allegations as were submitted by the Parties. The Award is DETERMINED as follows:

Injured Person(s) hereinafter referred to as: R.B.

1. ORAL HEARING held on 10/28/03.

2. ALL PARTIES APPEARED at the oral hearing(s).

   Respondent appeared telephonically.

3. Claims in the Demand for Arbitration were NOT AMENDED at the oral hearing (Amendments, if any, set forth below). STIPULATIONS were not made by the parties regarding the issues to be determined (Stipulations, if any, set forth below).

4. FINDINGS OF FACTS AND CONCLUSIONS OF LAW:

R.B. was involved in a motor vehicle accident on 7/3/02 from which the within matter arises.

Nature of Dispute:

I. Is claimant entitled to additional reimbursement as to services on 7/8/02, 8/26/02, 9/11/02, 10/16/02, 11/6/02, 3/19/03 and 4/16/03?
II. Was EEG and BAEP testing on 7/30/02 and EMG/NCV testing on 9/18/02 reasonable and medically necessary?

III. Are services from 11/20/02 on reasonable and medically necessary?

The following documentation was submitted for consideration and reviewed:

Claimant:
Demand filed 6/27/03 including billing statement, bills, patient information, police report, operative reports, EOBs, Pre-certification requests, treatment plans, examination notes, 7/8/02 and 11/11/02 narrative report, 8/8/02 report of Cranio Associates, letters to provider, MRI reports, letter of medical necessity, EMG/NCV testing results and assignment.
Submission dated 7/8/03 including report dated 6/30/03.
Submission dated 8/28/03 including letter memorandum, EOBs for other carriers, certification of Dr. Sabato, bills, EOBs and Pre-certification requests.
Certification of Attorney Services

Respondent:
Submission dated 8/13/03 including: letter memorandum, PIP payment ledger, EOBs, exam notes, PA Reviews of Drs. Gerstenblitt & Null, IME report of Dr. Gupta.

I also heard the arguments of counsel.

I. The initial consultation on 7/8/02 was billed under CPT code 99245. Respondent recoded the charge to CPT code 99205 which is the highest level for a new patient examination.

A new or established patient consultation billed under CPT code 99245 is defined as being “moderate-high severity” in nature and involving 80 minutes with the patient.

The examination requires two of the following three components:

- a comprehensive history
- a comprehensive examination
- medical decision making of high complexity

A new patient examination billed under CPT code 99205 is defined as being “moderate-high severity” in nature and involving 60 minutes with the patient.

The examination requires two of the following three components:

- a comprehensive history
- a comprehensive examination
- medical decision making of high complexity
The HICF form submitted by claimant does not identify a referring physician which would be necessary to properly bill a consultation (defined as a type of service requested by another physician) under CPT 99245. The claimant first saw the patient 5 days post-accident and the report does not state the patient was seen at the request of a referring doctor. As such, respondent maintains CPT 99205 was the proper code and reimbursement was made accordingly. I find that the records do not support the charge for CPT 99245. As such, reimbursement was proper under CPT code 99205.

Follow up examinations on 8/26/02, 9/11/02, 10/15/02 and 11/6/02 were recoded from CPT code 99215 to CPT code 99214 to reflect the code that "best describes the service." Date of service 3/19/03 and 4/16/03 were paid in error according to respondent. The charges were also recorded from 99215 to 99214. The EOB of respondent indicates that date of service 4/6/03 was paid, however, this appears to have been a clerical error based on the records. I find that payment was rendered and should be applied to date of service 4/16/03.

An established patient examination billed under CPT code 99215 is defined as being “moderate-high severity” in nature and involving 40 minutes with the patient.

The examination requires two of the following three components:

- a comprehensive history
- a comprehensive examination
- medical decision making of high complexity

An established patient examination billed under CPT code 99214 is defined as being “moderate-high severity” in nature and involving 25 minutes with the patient.

The examination requires two of the following three components:

- a detailed history
- a detailed examination
- medical decision making of moderate complexity

My review of the records and coding descriptions indicates the provider is not justified in billing the higher level code on 9/11/02, 11/6/02, 3/19/03 and 4/16/03 and therefore, no further reimbursement is owed for those dates of service. Based on the records, the provider is owed $86.94 for dates of service 8/26/02 and 10/16/02

II. R.B. began treating with claimant on 7/8/02. The patient is noted to have suffered a head trauma during the impact. Upon initial examination, the patient complained of blurred vision, tinnitus, headaches, left knee tenderness, left leg pain and weakness, neck pain with tingling, numbness and weakness into the left arm/hand as well as lower back pain. Spasm and restricted range of motion were noted on examination of the lumbar and cervical spine. TMJ tenderness was noted. The examination of the lower extremities revealed positive orthopedic tests as well as sensory loss and weakness to the left
extremity. The examination of the upper extremities revealed weakness and sensory loss to the left upper extremity.

BAER and EEG were ordered to evaluate post-traumatic brain syndrome and both tests revealed normal results. An MRI of the cervical and lumbar spine revealed herniations in both regions. The patient is noted to have been in a prior accident resulting herniations in the spine. An MRI of the brain was also ordered and revealed normal results. EMG/NCV studies were performed on 9/18/02 revealing evidence of cervical and lumbar radiculopathy. Epidurals were performed. The patient was discharged on 4/16/03.

Respondent denied payment for the EMG/NCV testing based upon a physician advisor determination by Dr. Null. Dr. Null concludes that there was no adequate neurologic examination to note any radiculopathy. As such, there was inadequate justification for the lower extremity EMG/NCV studies.

The EEG and BAER studies were denied based upon a physician advisor determination by Dr. Gerstenblitt. Dr. Gerstenblitt opines that a brain MRI would be the appropriate test for the patient's symptoms and there was no indication that a brain MRI had been done prior to these tests. Further, the patient suffers from diabetes which could have caused the symptoms in question.

Under Miltner vs. Safeco Ins. Co. of America, 175 N.J.Super. 156 (Law Div. 1980), where there is a dispute as to PIP benefits, the burden rests on the claimant to establish that the services for which he seeks PIP Payment were reasonable, necessary and causally related to an automobile accident. Claimant must carry that burden by a preponderance of the evidence. See, State v Seven Thousand Dollars, 136 N.J. 233 (1994). Pursuant to the administrative code, a medically necessary treatment or test is "consistent with the clinically supported symptoms, diagnosis or indications of the injured person" and "is the most appropriate level of service that is in accordance with good practice and standard professional treatment protocols including the Care Paths [applicable to spinal injuries]. N.J.A.C. 11:3-4.2.

Certain diagnostic tests are recognized as having value in the evaluation and treatment of patients and are reimbursable when medically necessary and consistent with clinically supported findings.

Pursuant to N.J.A.C. 11:3-4.5(b)(1), EMGs are reimbursable "when used in the evaluation and diagnosis of neuropathies and radicular syndrome where clinically supported findings reveal a loss of sensation, numbness or tingling." Similarly NCV studies are "reimbursable when used to evaluate neuropathies and/or signs of atrophy." N.J.A.C 11:3-4.5(b)(3).

The patient presented with pain in the low back and left lower extremity. The examination of the lower extremities revealed positive orthopedic tests as well as sensory loss and weakness to the left extremity. Dr. Null does not address any of these symptoms. Based on the weight of the credible evidence, I find that claimant has
sustained its burden as to the medical necessity of the lower extremity EMG/NCV. Sufficient clinically supported symptoms were presented suggesting neurologic deficit relating to the lumbar spine. The provider is owed $907.24.

N.J.A.C. 11:3-4.5(3) provides that EEGs should be performed to evaluate head injuries when there is an altered level of sensorium or suspicion of a seizure disorder. There is no indication of either is this patient. Mental status is noted as normal. Brain auditory testing is also recognized as a permitted test. The patient presented with head trauma and auditory symptoms (tinnitus). Tinnitus is not a symptom identified by Dr. Gerstenblitt as relating to diabetes and there is no support presented as to his conclusion that an MRI should be performed first or in lieu of the tests. I find that claimant has sustained its burden as to the medical necessity of the BAER testing, but not as to the EEG test. Thus, the provider is owed $350.

III. Treatment after 11/20/02 was denied based upon the IME by Dr. Gupta. Dr. Gupta examined R.B. on 11/11/02. The examination was completely non-focal. There was no spasm, extremity weakness or decreased reflexes. Sensory exam was normal. Dr. Gupta reviewed the cervical and lumbar MRI findings and concluded that there were arthritic changes and no significant lateral disc herniation present. Dr. Gupta concluded that the patient suffered from a minor strain and there were no objective findings to account for the patient's complaints. As such, no further care was warranted.

Claimant responded to the conclusions reached by Dr. Gupta. Initially, there was no notation as to whether tenderness or restricted range of motion was noted. Claimant also states that positive findings/limitations on examination were noted through discharge. Claimant also points out that herniations were, in fact, noted in the cervical and lumbar spine contrary to Dr. Gupta's assertions.

Based on the weight of the credible evidence, I find that claimant has sustained its burden as to the medical necessity of the additional care. Clinically supported symptoms were consistently noted in this patient, e.g. spasm, restricted motion, sensory loss and positive orthopedic tests. The patient complained of continuing problems at the examination with Dr. Gupta. The patient is noted to have responded positively to the epidurals and trigger point injections administered after the termination. Herniations (descending into the spinal canal) are, in fact, noted on the MRIs. Further, there is no indication that Dr. Gupta considered the EMG/NCV testing which suggested radiculopathy at right C4-6, left C5-6 and left L5-S1. Thus, I award $5,714.76 for services 11/20/02 to 3/7/03.

An interest calculation was presented in this matter. In accordance with the determinations above, I award interest in the amount of $131.05.

5. MEDICAL EXPENSE BENEFITS:

Awarded

<table>
<thead>
<tr>
<th>Provider</th>
<th>Amount Claimed</th>
<th>Amount Awarded</th>
<th>Payable to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology &amp; Pain Management Associates</td>
<td>$7,687.94</td>
<td>$7,058.94</td>
<td>Provider</td>
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Explanations of the application of the medical fee schedule, deductibles, co-payments, or other particular calculations of Amounts Awarded, are set forth below.

The amount awarded is subject to the New Jersey Fee Schedule, co-payment and deductible obligations of R.B.

6. INCOME CONTINUATION BENEFITS: Not In Issue

7. ESSENTIAL SERVICES BENEFITS: Not In Issue

8. DEATH BENEFITS: Not In Issue

9. FUNERAL EXPENSE BENEFITS: Not In Issue


   (A) Other COSTS as follows: (payable to counsel of record for CLAIMANT unless otherwise indicated): $285

   (B) ATTORNEYS FEES as follows: (payable to counsel of record for CLAIMANT unless otherwise indicated): $1,200.00

   (C) INTEREST is as follows: Awarded in the amount of $131.05.

This Award is in **FULL SATISFACTION** of all Claims submitted to this arbitration.
6/23/03
Date

Nanci G. Stokes, Esq.