In the Matter of the Arbitration between

Interstate Multi-Specialty Medical Group a/s/o F.G.
CLAIMANT(s),

v.

NJ PLIGA
RESPONDENT(s).

Forthright File No: NJ1810001811718
Proceeding Type: In-Person
Insurance Claim File No: NJUM-1712946-00001
Claimant Counsel: Midlige Richter
Claimant Attorney File No: 162.0158
Respondent Counsel: O'Toole, Couch & Della Rovere, LLC
Respondent Attorney File No: 16479-JOT
Accident Date: 06/09/2017

Award of Dispute Resolution Professional

Dispute Resolution Professional: Joseph Della Badia Jr., Esq.

I, the Dispute Resolution Professional assigned to the above matter, pursuant to the authority granted under the "Automobile Insurance Cost Reduction Act", *N.J.S.A. 39:6A-5, et seq.*, the Administrative Code regulations, *N.J.A.C. 11:3-5 et seq.*, and the *Rules for the Arbitration of No-Fault Disputes in the State of New Jersey* of Forthright, having considered the evidence submitted by the parties, hereby render the following Award:

Hereinafter, the injured person(s) shall be referred to as: FG

In Person Proceeding Information

A proceeding was conducted on: 07/11/2019

Claimant or claimant's counsel appeared by telephone . Respondent or respondent's counsel appeared in person .

The following amendments and/or stipulations were made by the parties at the hearing:

None

Findings of Fact and Conclusions of Law

This matter arises out of an automobile accident which occurred on June 9, 2017. Prior to rendering this decision, I have reviewed all documentation submitted by the parties. Oral argument of counsel was heard at the arbitration hearing conducted on July 11, 2019.

The consolidated cases and claims for medical expense benefits are as follows:

Interstate Multi-Specialty Medical Group a/s/o FG v. NJ PLIGA

Forthright# 1811718

Demand $90,781.91

Hudson Regional Hospital a/s/o FG v. NJ PLIGA

Forthright# 1805326

Demand $88,322.16 (amended)

Accelerated Surgical Center a/s/o FG v. NJ PLIGA

Forthright# 1789407

Demand $10,228.88

Neurophysiologic Interpretive Specialist a/s/o FG v. NJ PLIGA

Forthright # 1807336

Demand $5,618.46

Accurate Monitoring LLC a/s/o FG v. NJ PLIGA

Forthright # 1807345

Demand $4,844.97

This award will address all cases, although the issue of fees and costs, if applicable, will be addressed separately.

Issues

The issues, as identified by the parties and more specifically addressed below, are as follows:

1. Was the pain management treatment performed from 12/27/17-8/22/18 medically necessary? (Accelerated Surgical Center)
2. Was the cervical spine surgery of 5/3/18 medically necessary? If so, what is the proper rate of reimbursement? (Inter State Multi-Specialty Medical Group)
3. Were CPT 84703, 72020-TC, 76000-TC and 80305 improperly unbundled? (Hudson Regional Hospital)
4. Are Neurophysiologic Interpretive Specialist and Accurate Monitoring entitled to reimbursement for intraoperative monitoring performed in connection with the cervical spine surgery of 5/3/18? If so, should a pre-certification penalty apply?

No other issues were raised at the arbitration hearing or will be addressed, including any other issues and/or arguments which may have been raised in either party's pre or post hearing submissions but were not specifically presented to the undersigned at the time of the hearing.

Medical Necessity

Applicable Law

When there is a dispute as to the services provided, the burden rests upon the claimant to establish that the medical expenses for which it seeks PIP benefits were reasonable, necessary and causally related to an automobile accident. See Miltner v. Safeco Ins. Co. of Am., 175 N.J. Super. 156 (Law Div. 1980).

N.J.A.C. 11:3-4.2 Definitions, state in pertinent part:

"Medically necessary" or "medical necessity" means that the medical treatment or diagnostic test is consistent with the clinically supported symptoms, diagnosis or indications of the injured person, and: 1. The treatment is the most appropriate level of service that is in accordance with the standards of good practice and standard professional treatment protocols including the Care Paths in the Appendix, as applicable.

"Clinically supported" means that a health care provider prior to selecting, performing or ordering the administration of a treatment or diagnostic test has:

1. Personally examined the patient to ensure that the proper medical indications exist to justify ordering the treatment or test;
2. Physically examined the patient to ensure that the proper medical indications exist to justify ordering the treatment or test;
3. Considered any and all previously performed tests that relate to the injury and the results and which are relevant to the proposed treatment or test; and
4. Recorded and documented these observations, positive and negative findings and conclusions on the patient's medical records.

The necessity of medical treatment is a matter to be decided in the first instance by the claimant's treating physicians, and an objectively reasonable belief in the utility of a treatment or diagnostic method based on the credible and reliable evidence of its medical value is enough to qualify the expense for PIP purposes. Thermographic Diagnostics, Inc. v. Allstate Ins. Co., 125 N.J. 491 (1991).

Additionally, pursuant to Case Law developed in this State, where there is a conflict of testimony of medical experts, generally greater weight is to be given to the testimony of the treating physician. Mewes v. Union Bldg. & Const. Co., 45 N.J. Super. 88 (App. Div. 1957); Bialko v. H. Baker Milk Co., 38 N.J. Super. 169 (App. Div. 1955); Abelit v. General Motors Corp., 46 N.J. Super. 475 (App. Div. 1957). While it is true the treating physician's opinion is not automatically accorded conclusive weight, Black & Decker Disability Plan v. Nord, 123 S. Ct. 1965 (2003), (relating to ERISA Plans), it is accorded an appropriate measure of deference. Further, the treating physician enjoys wide discretion in determining the extent of treatment needed for a particular patient since it is not unusual for there to be a genuine dichotomy of medical opinion as to the type and extent of treatment needed for a particular injury. Elkins v. N.J. Mfrs. Ins. Co., 244 N.J. Super. 695 (App. Div. 1990).

Summary

Interstate Multi-Specialty Medical Group seeks reimbursement for cervical spine surgery on 5/3/18. Hudson Regional Hospital seeks reimbursement for facility fees associated with the surgery.

Neurophysiologic Interpretive Specialist and Accurate Monitoring seek reimbursement for the intraoperative monitoring services provided in connection with the surgery. Accelerated Surgical Center seeks reimbursement for the facility fees associated with pain management procedures to the cervical and lumbar spine performed from 12/27/17-8/22/18.

Accelerated Surgical Center

Claimant seeks reimbursement for cervical epidural injections on 12/27/17 and 1/10/18, cervical facet injections on 1/24/18, lumbar epidural injections on 7/25/18 and 8/8/18 and lumbar facet injections on 8/22/18.

Claimant states that the patient was involved in a motor vehicle accident on 06/09/17, when she was a pedestrian who was struck. She was taken by ambulance to the hospital emergency room following the subject accident, and subsequently began treating with Interstate Multi-Specialty Group to address neck and back pain that had been troubling them since. The patient had no prior accidents.

The patient presented to Interstate for a follow-up evaluation on 12/20/17, having undergone greater than 3 months of conservative care. The patient presented with continued complaints of neck pain, rated 10/10, with radiation to the bilateral upper extremities; pain in the midback, rated 6/10; pain in the low back, rated 8/10, with bilateral SI pain and radiation to the bilateral buttocks and right thigh; and daily headaches. Additionally, the patient noted numbness, tingling, and weakness in the bilateral upper extremities and right leg. That patient ambulated with an antalgic gait at this time.

It was noted that recent cervical and lumbar MRIs revealed disc bulges at C3-4, C4-5, and C5-6, disc herniation at C5-6, disc bulge at L4-5, and disc herniations at L4-5 and L5-S1. Additionally, a recent EMG/NCV study revealed cervical radiculopathy affecting the C5 and C6 root levels bilaterally and bilateral peroneal motor neuropathy.

An examination revealed: marked tenderness over the cervical, thoracic, and lumbar spine; muscle spasms of the bilateral cervical paraspinals, bilateral trapezius, bilateral thoracic paraspinals, bilateral lumbar paraspinals, left quadriceps, and left hamstring; cervical compression test was positive; decreased muscle strength was noted at the right triceps and left hand grip; decreased sensation was noted over the left shoulder; diminished bilateral patellar reflexes were noted. Cervical flexion was 25', cervical extension 15', cervical right rotation 45' and left rotation 15', cervical right tilt 25' and left tilt 10', lumbar flexion was 25', lumbar extension 5', lumbar right rotation 25' and left rotation 10', lumbar right lateral 10' and left lateral 5'. Straight leg raise was positive bilaterally. Range of motion was decreased in both shoulders.

After this examination, the doctor recommended the patient undergo a cervical epidural steroid injection to aid in pain management and enhance the patient's range of motion of the affected area. This recommendation was based on the physical exam findings, aforementioned diagnostic testing indicating the patient's neck pain was discogenic in nature, and the failure of conservative care to result in adequate or permanent relief of the patient's pain. The doctor noted the patient's response to this procedure would determine the future plan of care.

The first cervical epidural injection at C7-T1 was performed on 12/27/17 at Accelerated Surgical Center.

Following the initial cervical injection, Dr. Gorman noted in the operative report the patient tolerated the procedure well. The patient's discharge instructions indicate Dr. Gorman recommended the patient undergo a second cervical epidural in 2 weeks from the original injection.

Based on this recommendation, the patient underwent a second cervical epidural injection on 01/10/18

at Accelerated Surgical Center.

Following the second cervical epidural, the patient was re-evaluated. There was noted cervical pain, rated 8/10, with radiation to the bilateral upper extremities, and lumbar pain rated 8/10. It is noted that the patient failed to experience improvement in their symptoms following the second cervical epidural. Additionally, decreased range of motion and sensory/motor function was noted in the cervical spine, cervical compression test was positive, tenderness to palpation over the facet joints was noted C3 and Tl; lumbar range of motion and sensory/motor function was decreased with tenderness to palpation over the facet joints at Ll and S1.

Based on this re-evaluation and the failure of the epidural injections to provide adequate relief, the patient was subsequently instructed to undergo bilateral cervical facet joint block at C5-6 C6-7, and C7-T1. The cervical facet block was performed on 01/24/18 at Accelerated Surgical Center.

The patient presented for a follow-up at Interstate on 02/07/18, with continued complaints of pain in the neck, rated a 7/10, with radiation, numbness, tingling, and weakness in the bilateral upper extremities, and pain in the low back, rated a 7/10, SI pain, rated an 8/10, and radiation to the bilateral buttocks and right thigh. The patient was ambulating with an antalgic gait with the assistance of a cane. As a result of the patient's cervical pain failing to respond to both conservative and interventional pain management measures, the patient ultimately underwent a cervical discogram on 02/07/18, followed by an anterior cervical discectomy and fusion on 05/30/18.

The patient presented for a follow-up at Interstate on 07/11/18, noting some improvement in her cervical symptoms following the discectomy and fusion. However, she continued to complain of unchanged low back pain, rated 8/10, SI pain, rated 8/10, and radiation to the bilateral buttocks and thighs with weakness noted in the left leg.

An examination revealed, in relevant part, marked tenderness over the lumbar spine; muscle spasms of the bilateral lumbar paraspinals, bilateral gluteus, and bilateral quadriceps; lumbar flexion was 25', lumbar extension 5', lumbar right and left rotation 10', lumbar right and left lateral 5'; straight leg raise was positive bilaterally; tenderness was noted at the L4-5, L5-S1 spinal levels. It is again noted that the lumbar MRI revealed disc bulging at L4-5 and disc herniations at L4-5 and L5-S1.

After this examination, the doctor recommended the patient undergo a first lumbar epidural injection to attempt to reduce leg pain and decrease radicular symptoms and numbness related to the nerve root.

The first lumbar epidural was performed on 07/25/18 at Accelerated Surgical Center.

Following the first lumbar epidural, the patient was re-evaluated. Lumbar pain was rated at 6/10, which was an improvement from the pre-injection level of 8/10. However, radiation to the bilateral lower extremities was still noted, with decreased range of motion and sensory/motor function in the lumbar spine.

Based on this re-evaluation, it was recommended the patient undergo a second lumbar epidural, which was performed on 08/08/18 at Accelerated Surgical Center. It is noted within the operative report that the patient responded well the second lumbar epidural, experiencing immediate pain relief.

In its supplemental submission, Claimant highlights that while treating with Interstate Multi Specialty Group, the patient underwent two cervical epidural injections, one cervical facet injection, and two lumbar epidural injections.

Following the second lumbar epidural injection, the patient reported low back pain rated 8-10/10. Physical examination revealed difficulty and restrictions with lumbar range of motion, specifically:

flexion 40', bilateral lateral flexion 15', extension 15'. Additionally, muscle spasms were noted over the lumbar paraspinals and piriformis muscles. Tenderness on palpation was noted over the L3-4, L4-5, and L5-S1 facet joints.

Taking into account the patient's continued lumbar pain and aforementioned examination, Dr. Gorman recommended the patient undergo lumbar facet injections at this time. He went on to explain they are both diagnostic and therapeutic, numbing only the facet joints. A positive response, even temporary, can lead to a diagnosis of facet joint syndrome and therefore guide future treatment in the form of additional facet injections or radio frequency rhizotomy of the actual nerves.

The lumbar facet injections were performed on 08/22/18 at Accelerated Surgical Center. It was noted the patient experienced immediate pain relief.

Claimant argues that the treatment provided was based on objective evidence of injury, the patient's detailed complaints and feedback, and a full explanation was provided by the treating physicians of the basis for the procedures.

Respondent argues that medical necessity has not been established for the pain management injections and states that additional injections were denied as per the recommendation of Dr. Joseph Weber-Lopez. He pointed out that the most recent examination performed on or about 1/4/18 was limited in nature. For example, Dr. Weber-Lopez said that a neurological examination was not documented and there was no evidence of sensory deficits or decreased motor strength. He also noted that there was no evidence of 50% pain relief for six to eight weeks post first injection or an acute exacerbation of pain or new onset of radicular symptoms. Accordingly, additional injections were denied.

Findings

After considering the arguments and documentation presented, I find that the Claimant has proven by a preponderance of the evidence that the cervical epidural injection of 12/27/17 was medically necessary. I find that the treatment was consistent with the clinically supported symptoms, diagnosis and indications of the patient. The patient had failed a course of conservative care and had continuing radicular complaints in the cervical spine with positive objective findings on physical examination as well as disc herniation being found on the lumbar MRI at C5/6. In addition, EMG/NCV testing was positive for cervical radiculopathy at C5/6. Further, Respondent has not provided a medical necessity denial from a physician disputing the medical necessity of the service. Accordingly, I find that the Claimant is entitled to reimbursement. In regard to the cervical epidural injection of 1/10/18, I find that the Claimant has failed to prove by a preponderance of the evidence that it was medically necessary. As noted by Respondent's reviewing physician, Dr. Weber-Lopez, the record evidence fails to document any clinically significant improvement and no evidence of 50% pain relief after the prior cervical epidural injection to support the medical necessity of the second cervical epidural injection. As the finder of fact, I find that the documentation is insufficient to establish medical necessity for the cervical injection on 1/10/18 and reimbursement is therefore denied.

In regard to the cervical facet injections on 1/24/18, Respondent noted at the hearing that it had provided an explanation of benefits (EOB) documenting the claimant had been reimbursed for the date of service subject to a pre-certification penalty. Accordingly, and as Claimant has not disputed the precertification penalty, Respondent argues that no further reimbursement is due.

After reviewing the documentation and Respondent's EOB documenting payment, and noting that the Claimant has not disputed that a precertification penalty should apply to the date of service, I find the Claimant has been properly reimbursed and no further reimbursement is due.

In regard to the lumbar epidural injections of 7/25/18 and 8/8/18, as well as the lumbar facet injections of 8/22/18, I find that the Claimant proven by a preponderance of the evidence that they were medically necessary. Respondent has not provided a medical necessity denial disputing that the services were medically necessary or disputing the treating providers opinion that the lumbar injections were clinically supported. Based on the foregoing and the record evidence presented, including the subjective complaints and objective findings noted in the medical record, I find the Claimant has established that the injections were medically necessary and Claimant is therefore entitled to reimbursement.

Based on the foregoing, Accelerated Surgical Center is awarded $6,986.16.

Interstate Multi-Specialty Medical Group

The patient presented to Interstate Multi-Specialty Group's office on 11/08/17 following a motor vehicle accident on 06/09/17 wherein she was a pedestrian who was struck. She was taken by ambulance to the hospital emergency room following the subject accident. The patient had undergone greater than 3 months of conservative treatment for pain that was troubling since the accident and had no prior accidents of note.

Since the accident and upon presentation, the patient complained, relative in part, of neck pain, rated 8/10, with radiation to the bilateral shoulders, left arm, bilateral hands; numbness and tingling to the bilateral hands; and weakness in the bilateral arms.

The physical examination found decreased cervical range of motion as well as marked tenderness over the cervical spine; muscle spasms of the bilateral cervical paraspinals, bilateral trapezius, and bilateral thoracic paraspinals; cervical compression test was positive; decreased muscle strength was noted of the right triceps and left hand grip; decreased sensation was noted over the left shoulder; range of motion was decreased in the bilateral shoulders. Tenderness was noted at the C4-5, C5-6, C6-7, and C7-T1 levels.

It was noted that a recent cervical MRI revealed disc bulges at C3-4, C4-5, and C5-6 and disc herniation at C5-6. The patient also underwent EMG/NCV testing on 12/05/17 which revealed: cervical radiculopathy affecting the C5 and C6 root levels bilaterally and bilateral peroneal motor neuropathy.

Accordingly, she was diagnosed, in relevant part, with cervicalgia and cervical disc disorder with radiculopathy.

Ultimately, the patient underwen**t** two cervical epidurals, on 12/27/17 and 01/10/18, and a set of cervical facet injections, on 01/24/18.

As explained by Dr. Weissman in his post-service appeal narrative, following the epidural and facet injections the patient's pain relief was temporary, with pain returning within a few days and radicular symptoms persisting. As a result, the patient was referred for a cervical discography to determine a pain indicator. The procedure was performed on 02/07/18 with results that were positive with concordant neck and upper extremity pain at C4-5 and C5-6.

Based on these results the patient was referred to NJ Spine & Orthopedic for a surgical consultation. This consultation was conducted 6 days later on 02/13/18. At this time the patient continued to complain, relative in part, of neck pain, an inability to move her head, bilateral upper extremity numbness and tingling, and bilateral shoulder pain.

Following an examination, Dr. Slaughter recommended the patient undergo anterior cervical spinal cord decompression with bilateral foraminotomy and disc arthroplasty. It should be noted that the discogram results were consistent with the ultimate surgery performed on 05/03/18.

As Dr. Weissman stated in his appeal narrative, this patient had failed conservative care, there were positive MRI findings, positive EMG/NCV findings, ineffective injection treatment, a positive discography, and continued severe pain. As such she was an excellent candidate for the cervical decompression which was performed on 05/03/18.

Based on the foregoing, Claimant argues that it is entitled to reimbursement for the medically necessary surgery.

Respondent argues that the Claimant has failed to establish the cervical spine surgery was medically necessary. In support of its argument, Respondent relies on the opinion of Dr. Sean Lager, a board certified orthopedic surgeon. Based on his review, the patient's last physical exam by a treating doctor was 2/22/18 and was limited in nature. He concluded that medical necessity was not established "based on a lack of objective evidence." Dr. Regina Hillsman reviewed the evidence following an appeal and upheld the denial. She determined that claimant's letter of appeal did not include additional clinical information findings. She also noted that the 2/13/18 evaluation report did not show complete clinical examination findings due to the patient's "emotional liability." She concluded that there were "no progressive neurological deficits or neurological findings to justify cervical disc decompressive surgery." Accordingly, Respondent argues that medical necessity has not been established for the cervical surgery and the claim for benefits should be denied.

Findings

After considering the arguments and documentation presented, I find that the Claimant has proven by a preponderance of the evidence that the cervical spine surgery of 5/3/18 was medically necessary. After weighing the evidence presented, I find that the record evidence and the opinion of the treating providers outweighs that of Respondent's reviewing physician, while noting that there was no physical examination performed of the patient on behalf of Respondent. The record evidence indicates that the patient had failed a course of conservative care and continued to complain of radicular symptoms in the cervical spine. The patient had also undergone cervical epidural injections with limited benefit. MRI testing revealed multilevel disc bulging and disc herniation at C5/6 and EMG/NCV testing confirmed radiculopathy at C5/6. Cervical discography was positive for concordant pain in the upper extremity at C4-5 and C5-6. The record evidence further indicates that the patient was complaining of intractable neck pain which was affecting her activities of daily living. Given the foregoing, Dr. Slaughter recommended the patient undergo anterior cervical spinal cord decompression with bilateral foraminotomy and disc arthroplasty at C4/5 and C5/6, which was performed on 5/3/18. The review by Respondent's physician, Dr. Lager, ignores the positive MRI findings, positive EMG/NCV testing and positive discogram in determining that the surgery was not medically necessary. I find his opinion to be unpersuasive. As noted above, based on the weight of the evidence presented, I find that the Claimant has established clinical support for the cervical spine surgery and Claimant is therefore entitled to reimbursement subject to the findings noted below.

Reimbursement of Cervical Spine Surgery (5/3/18)

Claimant seeks reimbursement for the following CPT codes in connection with the cervical spine surgery on 5/3/18: CPT 22856-62, 22858-62, 22551-62-69, 22552-62-59, 22845-62-59.

Respondent argues that if it is determined that the surgery was medically necessary, claimant is nevertheless precluded from reimbursement for CPT codes 22551, 22552 and 22845 as they were reported in error as per the coding report which Respondent relies upon and provides in its pre-hearing submission. According to the report, the anterior decompression, fusion and instrumentation was not documented to support the billing for the aforementioned codes.

Respondent states that if claimant is entitled to reimbursement for CPT codes 22551, 22552 and 22845, they should be cross-walked to codes that are on the fee schedule pursuant to N.J.A.C. 11:3-29.4 (e), which states in relevant part:

> The insurers limit of liability for any medical expense benefit for any service or equipment not set forth in or not covered by the fee schedule shall be a reasonable amount considering the fee schedule amount for similar services or equipment in the region where the service or equipment was provided.

Thus, CPT codes 22551 and 22552 should be cross-walked to CPT fee scheduled codes 22554 ($6,185.12) and 22585 ($1,650.20). Finally, CPT code 22845 is listed on the fee schedule for the amount of $4,518.17.

Claimant argues that the documentation and operative report supports reimbursement of CPT 22551, 22552 and 22845. Claimant further argues that Respondent's coding report is not by a physician and provides no support for its conclusion that the codes are not reimbursable. Claimant does not dispute that if the codes are reimbursable, CPT 22551 and 22552 should be cross walked as noted above for purposes of reimbursement. In its supplemental submission and in support of its position, Claimant provides a diagram from the American Medical Association of the anterior approach for cervical fusion under CPT 22554 and 22585.

After considering the arguments and documentation presented, I find that the documentation, specifically the operative report, supports reimbursement for the billed codes of CPT 22551 (crosswalked to CPT 22554), 22552 (crosswalked to CPT 22585) and 22845. There is no indication as to who performed Respondent's coding report or the person's qualifications to provide such a report. There is no explanation as to why the codes in dispute were allegedly reported in error or specifically how the documentation did not support reimbursement. I find that the operative report supports the codes billed and it is further noted that the documentation clearly supports that MOBI-C implants were documented and provided as per the operative report. Further, as argued by Claimant, Respondent has not provided any opinion from a physician in regard to the codes in dispute and I find no support for respondent's position. In addition, as referenced above, it is not disputed that CPT 22551 should be crosswalked to CPT 22554 and CPT 22552 should be cross walked to CPT 22585 for purposes of reimbursement pursuant to N.J.A.C. 11:3-29.4 (e). Accordingly, based on the foregoing, Interstate Multi Specialty Medical Group is awarded $90,163.09.

Hudson Regional Hospital

Claimant seeks reimbursement for CPT 22856 and 22858 in connection with the two level cervical disc arthroplasty, as well as separate reimbursement for supplies and implants in connection with the cervical spine surgery on 5/3/18, which was found to be medically necessary. Specifically, Claimant seeks reimbursement for following CPT codes (lab codes and x-rays), which Respondent argues were unbundled pursuant to N.J.A.C. 11:3-29.5(a) : 84703, 72020-TC, 76000-TC, 80305. Respondent further provides a code report from Steven Lisner, CPC, in support of its argument.

Claimant maintains that the lab codes as well as the x-rays and fluoroscopy are reimbursable under Medicare.

As per Medicare, labs services and x-ray and radiological services are reimbursable with outpatient surgery. Specifically, Medicare states:

1. Outpatient hospital services

Medicare Part B (Medical Insurance) covers medically necessary diagnostic and treatment services you get as an outpatient from a Medicare-participating hospital. Covered outpatient hospital services may include:

- Emergency or observation services, which may include an overnight stay in the hospital or outpatient clinic services, including same-day surgery
- Laboratory tests billed by the hospital
- Mental health care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be required without it
- X-rays and other radiology services billed by the hospital
- Medical supplies, like splints and casts
- Preventive and screening services
- Certain drugs and biologicals that you wouldn't usually give yourself Generally, Part B doesn't cover prescription and over-the-counter drugs you get in an outpatient setting, sometimes called "self-administered drugs." Also, for safety reasons, many hospitals have policies that don't allow patients to bring prescription or other drugs from home. If you have Medicare prescription drug coverage (Part D), these drugs may be covered under certain circumstances. You'll likely need to pay out-of-pocket for these drugs and submit a claim to your drug plan for a refund. Call your drug plan for more information.

Based on the foregoing, Claimant argues that it is entitled to separate reimbursement.

Claimant further argues that Respondent's coding report concedes that the MOBI-C implants (Rev 278) are reimbursable at invoice plus 20% pursuant to N.J.A.C. 11:3-29.4(f-8).

N.J.A.C. 11:3-29.5 states:

(a) ASC facility fees are listed in Appendix, Exhibit 1, by CPT code. Codes that do not have an amount in the ASC facility fee column are not reimbursable if performed in an ASC. The ASC facility fees include services that would be covered if the services were furnished in a hospital on an inpatient or outpatient basis, including:

1. Use of operating and recovery rooms, patient preparation areas, waiting rooms and other areas used by the patient or offered for use to persons accompanying the patient;

2. All services and procedures in connection with covered procedures furnished by nurses, technical personnel and others involved in the patient's care;

3. Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment;

4. Diagnostic and therapeutic items and service.

Appendix, Exhibit 1 indicates those CPT codes that, according to Medicare . . . are considered ancillary services that are integral to surgical procedures and are not permitted to be reimbursed separately in an ASC.

Appendix, Exhibit 7 indicates those services that, according to Medicare . . . are considered ancillary services that are integral to surgical procedures and are not permitted to be reimbursed separately in a HOSF.

5. Administrative, recordkeeping and housekeeping items and services;

6. Blood, blood plasma, platelets, etc.;

7. Anesthesia materials, including the anesthetic itself, and any materials, whether disposable or reusable, necessary for its administration; and

8. Implantable DME and prosthetics.

a. HOSF fees are listed on subchapter Appendix, Exhibit 7 by CPT code. The hospital outpatient surgical facility fee is the maximum that can be reimbursed for outpatient procedures performed in an HOSF. The hospital outpatient facility fees in Appendix Exhibit 7 include services that would be covered if furnished in a hospital on an inpatient basis, including those set forth in (a)1 through (8) above.

After considering the arguments and evidence presented, I find that the Claimant has failed to prove by a preponderance of the credible evidence that it is entitled to reimbursement for the above-noted CPT codes (84703, 72020-TC, 76000-TC, 80305). I find persuasive Respondent's argument that the codes were improperly unbundled pursuant to N.J.A.C. 11:3-29.5 and no reimbursement is due.

Respondent's coding report acknowledges that CPT 22856 and 22858 were documented appropriately for both co-surgeons and are reimbursable. The coding report further acknowledges that Claimant is entitled to reimbursement for the MOBI-C implants (Rev 278) at invoice plus 20 percent ($14,880.00) pursuant to N.J.A.C. 11:3-29.4(f-8).

Based on the foregoing, Hudson Regional Hospital is awarded $86,203.35.

Neurophysiologic Interpretive Specialist and Accurate Monitoring

Claimant Argument

The Claimants seek reimbursement for intraoperative monitoring performed in connection with the cervical spine surgery on 5/3/18. Claimants argue that the monitoring was medically necessary to identify compromise to the nervous system during the surgical procedure. Evoked responses are constantly monitored for changes that could imply damage to the nervous system. The operative report specifically indicates that the intraoperative monitoring was performed. Additionally, Claimants also rely on the "Letter of medical necessity for neurophysiologic interoperative monitoring" prepared by the surgeon in the instant matter, which indicated that the monitoring for this specific patient was medically necessary. The intent of this monitoring is to alert the surgeon so the surgical procedure may be altered to avoid permanent neurological damage.

Claimants further argues that the remote intraoperative monitoring performed in connection with the cervical surgery in this matter was completely permissible and that Claimants are entitled to full reimbursement.

Claimants argue that in regard to this matter, Respondent's defenses concerning the Board of Chiropractor and Board of Medical Examiners regulations and statutes should be rejected. Claimant states that the remote intraoperative monitoring by NIS's Dr. Steven Factor is completely permissible (as evidenced by the lack of legal authority introduced by Respondent to support its position) and the Accurate Monitoring technologist Tiffany Y. Barrerau (married name is now Tiffany Furr) was properly certified in neurophysiologic intraoperative monitoring ("CNIM" certified) by the American Board of Registration of Electroencephalographic and Evoked Potential Technologists.

Furthermore, diagnostic EMG/NCV testing for the purpose of establishing a diagnosis is not involved in this matter and therefore any issues concerning such testing do not apply herein.

As to the professional component (NIS), Dr. Factor rendered the real-time interpretation of the monitoring. The actual monitoring undoubtedly was performed by a Medical Doctor.

As to the location of Dr. Factor during the intraoperative monitoring, it is not disputed that the monitoring was performed remotely. However, there is no prohibition against the remote provision of these services. Indeed, Respondent does not cite any legal authority to support any argument that remote provision is not permitted.

Furthermore, the American Medical Association (AMA) position on intraoperative monitoring is as follows:

> Our AMA policy is that supervision and interpretation of intraoperative neurophysiologic monitoring constitutes the practice of medicine, which can be delegated to non-physician personnel who are under the direct or online real time supervision of the operating surgeon or another physician trained in, or who has demonstrated competence in, neurophysiologic techniques and is available to interpret the studies and advise the surgeon during the surgical procedures.

In short, there is no prohibition on remote monitoring, as performed in this matter. As the AMA's official policy makes clear, Dr. Factor properly performed the procedure remotely through a HIPPA compliant connection. Dr. Factor was not required to be physically present.

Further, the technologist, Tiffany Furr, CNIM, was qualified to perform the technical component of intraoperative monitoring as each was properly CNIM certified by ABRET Neurodiagnostic Certification and Accreditation.

It is undisputed that Claimants in this matter were performing neurophysiologic intraoperative monitoring services and not electrodiagnostic testing in an office setting in the context of chiropractic treatment.

Claimant further provides a letter from Dr. Cruz letter explaining the distinction between intraoperative monitoring and diagnostic EMG testing. Claimant highlights the fact that intraoperative monitoring is different from diagnostic EMG testing. Dr. Cruz believes there is a misunderstanding as to the nature of the intraoperative monitoring, and he has explained that clinical/diagnostic EMG is not performed during intraoperative monitoring. Dr. Cruz explains what neurophysiologic intraoperative monitoring services are as follows:

> "We do not perform clinical/diagnostic EMG instead we perform IONM (intraoperative NeuroMonitoring). This [is] a well-established practice during many spine and brain surgeries (as well as other surgeries) for decades where a technician, under the supervision of a physician, will set up various electrodes on a patient in the operating room to measure electrical signals produced by the nervous system to aid the surgeon in helping to avoid neurological damage. One of the many modalities that we perform is IONM EMG performed for a different reason, with different equipment, in a completely different environment than clinical EMG. The following is a description of the differences of EMG performed during Intraoperative NeuroMonitoring and the EMG performed as a diagnostic test in an office setting. Although these two tests are very different there is only one set of codes in the CPT book that they must share. This has led to much confusion. One of the codes for both diagnostic EMG and IONM EMG is 95861. Neurologists will use this code to denote that they did clinical/diagnostic bilateral EMG. However, the same code is used for IONM where we denote that we did IONM EMG. IOM code applications are listed in a different location in the CPT book under 95941, 95940, and G0453 (IONM hourly monitoring) where all the CPT

codes that can be used in conjunction with the hours spent in nerve monitoring are listed."

Dr. Cruz further explains a glaring difference between diagnostic EMG testing and intraoperative monitoring is one of intention. Intraoperative monitoring is performed to alert the surgeon as early as possible that they have done something that might injure a nerve, or to help locate a nerve. Diagnostic EMG, on the other hand, is performed in an office setting and is done to diagnose pathology. Dr. Cruz explains, "The key here is that it is necessary to have a physician do this since only a physician can give a patient a diagnosis. In stark contrast, the IONM technician is not diagnosing anything, actually they are conducting electrical stimuli along nerve pathways that are in, or very near to the surgical site. The purpose is to detect changes in baseline patterns that might delineate nerve interference or damage. They are being constantly supervised by a physician, remotely in all cases."

Dr. Cruz also explains diagnostic EMG may only be performed by a medical doctor, but IONM EMG can be performed by trained IONM technicians. Dr. Cruz attaches a position statement by the American Society of Electroneurodiagnostic Technologists (ASET). Dr. Cruz explains the different needles used for intraoperative monitoring compared to diagnostic EMG's. With intraoperative monitoring, the needles are small (1 inch) and are placed subcutaneously and wait during the entire case (sometimes for hours) to see if there is any electrical activity. On the other hand, needle EMG's involve much longer needles that are stuck into the muscle itself and manipulated to detect responses reported by the equipment used by the physician. The sounds and wave morphology assist the physician to determine if the patient has pathology. Dr. Cruz explains they are very different methods for different purposes.

Dr. Cruz concludes as follows:

> "IONM EMG should be considered as a separate test from diagnostic EMG. So, while I would agree that a physician is needed to perform Diagnostic EMG in order to generate a diagnosis, IONM EMG requires a trained IONM technician (see asset position paper) to perform the test, interpreted by a physician, so a surgeon can be noticed of any impending nerve damage or injury. Both applications should be recognized and paid accordingly.

In this case, the on-site technician was Tiffany Furr, CNIM, who holds a Certification in Neurophysiologic Intraoperative Monitoring ("CNIM") by the American Board of Registration of Electroencephalographic Technologies ("ABRET").

The State Board of Chiropractic Examiners regulation upon which Respondent relies, *N.J.A.C.* 13:44E-3.3 "Referable Tests" provides:

> (a) A chiropractic physician shall not perform the following, but may refer a patient to an appropriately trained medical doctor for the purpose of undergoing:
>
> (1) Needle electromyography (needle EMG) for the evaluation and diagnosis of neuropathies and radicular syndrome where clinically supported findings reveal a loss of sensation, numbness or tingling.

Respondent's reliance upon *N.J.AC.* 13:44E-3.3 and 3.5 with respect to diagnostic needle EMG testing performed by a chiropractor is clearly misplaced. *N.J.A.C.* 13:44E-3.3. (a)(1) is limited to "needle electromyography for the evaluation and diagnosis of neuropathies and radicular syndrome where clinically supported findings reveal a loss of sensation, numbness or tingling." As explained by Dr. Marcos Cruz, M.D., the intraoperative monitoring services at issue are completely distinct and separate from diagnostic needle electromyography performed "for the evaluation an diagnosis of neuropathies and radicular syndrome. .. ." The intraoperative monitoring that was performed by the technicians is this matter is not needle EMG "for the evaluation and diagnosis of neuropathies and radicular syndrome."

Moreover, *N.J.A.C.* 13:44E-3.1 contains the following definition of "diagnostic test"

> As used in this subchapter, the following words and terms have the following meanings, unless the context clearly indicates otherwise.
>
> "Diagnostic test" means a professional service utilizing biomechanical, neurological, neurodiagnostic, radiological, vascular or any means, other than bioanalysis, intended to assist in establishing a diagnosis, for the purpose of recommending a course of treatment for the tested patient to be implemented by a chiropractic physician or other treating practitioner."

The intraoperative monitoring at issue does not fall within the definition of "diagnostic test" pursuant to *N.J.A.C.* 13:44E-3.1 because it is "not intended to assist in establishing a diagnosis for the purpose of recommending a course of treatment."

Moreover, Respondent's reliance upon *N.J.S.A.* 45:9-5.2 is similarly misplaced given the distinction between diagnostic EMG with needles inserted into muscle and intraoperative monitoring EMG with needles inserted subcutaneously as explained by Dr. Cruz. Based upon the foregoing, Claimants maintain that the intraoperative monitoring services at issue were performed in accordance with controlling laws and regulations.

Claimant also argues that Respondent's reliance upon *N.J.A.C.* 45:9-5.2 is misplaced because this statutory provision does not apply to the intraoperative neurophysiologic monitoring services that were performed in this matter. *N.J.S.A.* 45:9-5.2(1)(b) defines "needle electromyography" as follows:

> "Needle electromyography" means the study of spontaneous and voluntary electrical activity of muscle, which is performed by insertion of a needle electrode into a muscle and recording the electrical activity at rest and during voluntary contraction."

In this case, as explained by Dr. Cruz, "[w]ith intraoperative monitoring, the needles are small (1 inch) and are placed subcutaneously and wait during the entire case (sometimes for hours) to see if there is any electrical activity. On the other hand, needle EMG's involve much longer needles that are stuck into the muscle itself and manipulated to detect responses reported by the equipment sued by the physician." Therefore, N.J.S.A. 45:9-5.2(1)(a) does not apply to the intraoperative neurophysiologic monitoring services at issue in this matter.

Second, Respondent's reliance upon *N.J.S.A.* 13:35-2.6(n)(1) is similarly misplaced. Pursuant to *N.J.S.A.* 13:35-2.6 (a), "[a]s used in this section, the following terms shall have the following meanings, unless the context clearly indicates otherwise.

> "Diagnostic test" means a medical service utilizing biomechanical, neurological, neurodiagnostic, radiological, vascular or any means, other than bioanalysis, intended to assist in establishing a medical diagnosis, for the purpose of recommending a course of treatment for the tested patient to be implemented by the treating practitioner or by the consultant.

In this case, as explained by Dr. Cruz, intraoperative neurophysiologic monitoring ("IONM") does not fit the definition of "diagnostic test" set forth in *N.J.S.A.* 13:35-2.6(a). Dr. Cruz explained that IONM "is performed to alert the surgeon as early as possible that they have done something that might injure a nerve, or to help locate a nerve. Diagnostic EMG, on the other hand, is performed in an office setting and is done to diagnose pathology."

The chiropractic regulation is inapposite to this matter because the SSEP services at issue were intraoperative monitoring services performed during back surgery and were not diagnostic testing services. Moreover, there is no indication whatsoever that the technologists were in fact chiropractors

too.

In addition, Respondent's contention that there is no showing that Claimants had privileges at Holy Name Medical Center is unfounded as the pertains to hospital staffing, is not applicable and should be disregarded.

Claimant also provides prior DRP decisions in support of its respective position.

Respondent Argument

In regard to medical necessity, Respondent relies on the above referenced MDR by Dr. Lager who denied that the cervical spine surgery was medically necessary. If the surgery was not medically necessary, then neither is the intraoperative monitoring and the claim for benefits should be denied.

In regard to the intraoperative monitoring, Respondent argues that Tiffany Borreau-Furr is not qualified to perform in-operating room technician services. Tiffany Borreau-Furr does not have the required training to perform electrodiagnostic testing.

On behalf of Respondent, Dr. Carmickle noted that, "for Ms. Tiffany Borreau to perform the EMG portion of monitoring is a deviation from the regulations set forth by the NJ Board of Chiropractic Examiners."

The State Board of Chiropractic Examiners provides "a chiropractic physician shall not bill for any diagnostic test that has not been reliably demonstrated to identify conditions amenable to chiropractic care." N.J.A.C. 13:44E-3.2. There has been no information provided that shows that the EMG test performed on this patient was a condition demonstrated to be amenable to chiropractic care.

State Board of Chiropractors Regulations: N.J.A.C. 13:44E-3.2 — Recognized Diagnostic Tests; Permissible Billing

> A chiropractic physician may perform a diagnostic test and charge a patient or third party payer for that test except as provided by N.J.A.C. 13:44E-3.2(b), "A chiropractic physician shall not bill for any diagnostic tests that have not been reliably demonstrated to identify conditions amenable to chiropractic care beyond information ascertainable from the taking of a patient history and performance of a thorough clinical examination or that otherwise fail to yield data of sufficient clinical value in the development, evaluation, or implementation of a plan of treatment including: 1) spinal diagnostic ultra stenography/ultrasound imaging of the spine; 4) reflexology."

Pursuant to the regulations, a chiropractic physician shall not perform, and may refer a patient to an appropriate trained medical doctor for: 1) Needle electromyography (Needle EMG) N.J.A.C. 13:44E-3.3. Based on the regulations, a chiropractor is not permitted to perform needle EMG testing and cannot bill for needle EMG testing.

The State Board of Chiropractic Examiners also indicates that a chiropractic physician could not perform a needle EMG.

> N.J.A.C. 13:44E-3.3(a) — A chiropractic physician shall not perform the following, but may refer a patient to an appropriately trained medical doctor for the purpose of undergoing: 1) needle electromyography (Needle EMG) for the evaluation and diagnosis of neuropathies and radicular syndrome where clinically supported findings reveal a loss of sensation, numbness or tingle; or 2) any test requiring administration of medication for effective performance.

There is also an issue regarding the monitoring performed by Steven Factor, D.O.. Neurophysiologic monitoring is required to be performed in real time and if a chiropractic physician is performing or interpreting electrodiagnostic tests, it must be directly supervised. N.J.A.C. 13:35-2.6(n). There is no indication that Steven Factor, D.O., was qualified to supervise the procedure and there is no indication that he was present to directly supervise the procedures even if he was qualified. Dr. Factor was neither present to perform the EMG nor was he present to oversee the EMG, but simply interpreted the results of the EMGNLY feed. Dr. Factor has not presented any information that he was present at Hudson Regional Hospital on the date of the EMG testing. It can be inferred based on the absence of proof that Dr. Factor was neither present to perform the EMG testing nor was he present to oversee the EMG. Instead, he interpreted the EMG over live video feed.

According to Dr. Carmickle's report, she stated:

> Dr. Factor also was not present and therefore was not available to personally perform the electromyography which is a further deviation from the state law.
>
> Dr. Cruz has observed that the techniques for intraoperative EMG testing are slightly different from those of diagnostic EMG studies as the needle is subcutaneous rather than using longer electrodes. The state regulations do not differentiate between these studies.

Board of Medical Examiners, N.J.A.C. 13:35-2.6(n) provides that any practitioner designated to be responsible for the management of a diagnostic office which operates without the full-time presence of an appropriately licensed and trained physician shall ensure that:

1. All invasive tests including transesophageal echocardiography and needle electromyography are personally performed and interpreted by the physician;
2. direct personal supervision by the physician whereby the physician is immediately available, is provided for all diagnostic tests requiring anesthesia or contrast as set forth in N.J.A.C. 13:35-4a and in particular N.J.A.C. 13:35-4a.8 —4a.11.

In addition to the foregoing there is also no indication that Tiffany Borreau nor Steven Factor, D.O. had hospital privileges at Hudson Regional Hospital as required by N.J.A.C. 8:43G-16.1. In her expert report, Dr. Carmickle noted the following:

> Furthermore, there is no indication that the individuals involved in the monitoring have privileges at Hudson Regional Hospital where the procedure was performed. This is required, pursuant to N.J.A.C. 8:43G-16.1.

a. Applications for membership, privileges, or initial appointment to the medical staff shall be processed under a system that includes, at least, the verification of applicants' credentials, periodic review of privileges, and obtaining information about any disciplinary action against the applicant available from the New Jersey Board of Medical Examiners or the Federal Clearinghouse established pursuant to the Health Care Quality Improvement Act, P.L. 99-660; 100 STAT 3743.
b. Applications for medical staff membership, clinical privileges, or initial appointment submitted by health professionals who are not practitioners, shall be reviewed according to the same established criteria and procedures that govern physicians' applications, including obtaining information about any disciplinary action by New Jersey professional licensing boards.
c. A committee or mechanism shall be established to be responsible for examining applications for appointment and reappointment to all categories of the medical staff. This committee shall recommend the conferring or withholding of all staff positions. It shall assure that all credentials are documented and verified.

d. Medical staff privileges shall be specifically delineated and based on the practitioner's training, experience and demonstrations of clinical competence.

> Hospital privileges are put in place by the hospitals to protect
> the public from individuals not permitted to perform procedures at the hospital. The need for hospital privileges allows for the individual performing the procedures to be vetted by the hospital and theoretically ensures that they are qualified to perform the procedures.

There is no indication that Tiffany Borreau or Steven Factor, D.O. had hospital privileges.

Respondent further states that the Appellate court held in Allstate v. Orthopedic Evaluations, supra, 300 N.J. Super. at 510, that in order to be eligible for PIP benefits a healthcare provider must be in compliance with significant qualifying requirements of law bearing on its service. Id. at 516. Here, the petitioner seeks reimbursement for neurologic interpretative monitoring services and EMG procedures which did not comply with significant qualifying requirements of law and violated numerous New Jersey statutes and regulations. Accordingly, as the procedure was not performed in accordance with statutes and regulations, PIP reimbursement is not permitted.

This includes: (1) the performance of electro-diagnostic testing by a practitioner who was not licensed to practice medicine and surgery in the State of New Jersey under N.J.S.A. 45:9-5.2; (2) the failure of a physician to personally direct and supervise procedures under N.J.S.A. 13:35-2.6(n)(1); (3) the failure to establish hospital privileges at Advanced Spine Surgery Center pursuant to N.J.A.C. 8:43G-16.1; and (4) the performance of procedures in violation of patient privacy under N.J.A.C. 8:43G-4.1(a)(20). Based upon these violations, the interpretive services and the lumbar procedure was not performed in accordance with significant qualifying requirements of law and therefore the petitioner is not entitled to reimbursement of PIP benefits.

Respondent states that the performance of electro-diagnostic testing by a practitioner who was not licensed to practice medicine and surgery in the State of New Jersey is not in accordance with applicable statutes and regulations.

N.J.S.A. 45:9-5.2 requires that "a person shall not perform needle electromyography unless that person is licensed to practice medicine and surgery in this State". Furthermore, "a person shall not interpret evoked potentials or nerve conduction studies unless that person is licensed to practice: medicine and surgery in this State pursuant to Chapter 9 of Title 45 of the Revised Statutes." N.J.S.A. 45:9-5.2 The performance of electro-diagnostic testing by a practitioner who was not licensed to practice medicine and surgery in the State of New Jersey under N.J.S.A. 45:9-5.2 violates applicable statutes and regulations and significant qualifying requirements of law.

Based on the regulations, a technician is not permitted to perform Needle EMG testing, and cannot bill for needle EMG testing. In this case, since the billing for the needle EMG testing was inappropriate as it was performed by a technician, the billing for SSEP is also inappropriate. A technician is never permitted to bill for EMG's. Even for a chiropractor to bill for SSEP, the chiropractic must have performed a surface EMG, not a needle EMG. The performance of electro-diagnostic testing by a technician who was not certified by the New Jersey Board of Medical Examiners to perform testing is in violation of N.J.S.A. 45:9-5.2.

In Selective Insurance Company v. Arthur Rothman, M.D., 208 N.J. 580 (2012), the New Jersey Supreme Court determined that a physician's assistant was not permitted to perform an EMG. The Supreme Court upheld the judgment of the Appellate Division finding that the plain language of N.J.S.A. 45:9-5.2(a) limits performance of EMG's to those who are licensed to practice medicine and surgery in the State of New Jersey. A chiropractor is not licensed to practice medicine and surgery under N.J.S.A.

45:9-5.1-5.2. A technician is not qualified to practice medicine and surgery under N.J.S.A. 45:9-5.2.

Respondent argues that in this matter, there is no showing of compliance with the NJ Board of Chiropractic Examiner or the New Jersey Board of Medical Examiner's requirements, therefore the testing was not performed in accordance with significant qualifying requirements of law and is not entitled to reimbursement.

Respondent further argues that the failure of a physician to personally direct and supervise the procedures violated N.J.S.A. 13:35-2.6(n)(1). There is no specification as to who performed the intraoperative monitoring. If it was performed by Steven Factor, D.O., it was performed off site. Dr. Factor was neither present to perform the EMG nor was he present to oversee the EMG but simply interpreted the results of the EMG via live feed, according to the HICF. The monitoring may have been performed by Steven Factor, D.O., but there is no indication that he was present to oversee the EMG. The reports indicate that a technician, Tiffany Borreau, performed the neurological testing and the EMG on the patient. According to the Board of Medical Examiners, N.J.S.A. 13:35-2.6(n)(1), any practitioner designated to be responsible for the management of a diagnostic office which operates without the full-time presence of an appropriately licensed and trained physician shall ensure that:

(n)

1. all invasive tests including transesophageal echocardiography and needle electromyography are personally performed and interpreted by the physician;
2. direct personal supervision by the physician whereby the physician is immediately available, is provided for all diagnostic tests requiring anesthesia or contrast as set forth in N.J.A.C. 13:35-4a and in particular N.J.A.C. 13:35-4a.8 — 4a.11.

According to the medical reports, Tiffany Borreau, a technician, performed the EMG testing at the Claimant hospital. The Board of Medical Examiners statute explicitly emphasizes that unless a person is licensed to practice medicine and surgery in the State of New Jersey, that individual cannot perform needle EMG testing and that individual cannot interpret nerve conduction studies: N.J.S.A. 45:9-5.2(a) provides that a person may not perform needle EMG unless "that person is licensed to practice medicine and surgery in this State pursuant to chapter 9 of Title 45 of the Revised Statutes." In addition, N.J.S.A. 45:9-5.2 also states, "A person shall not interpret evoked potentials or nerve conduction studies unless that person is licensed to practice: medicine and surgery in this State pursuant to chapter 9 of Title 45 of the Revised Statutes." The technician, Tiffany Borreau, is not permitted to perform the needle EMG testing.

In addition, Steven Factor, D.O. has not provided proof that he was present at Hudson Regional Hospital on the date of the EMG testing. It can be inferred based on the absence of proof that Dr. Factor was neither present to perform the EMG nor was he present to oversee the EMG. Instead, he interpreted the EMG over live video feed. Based on the Board of Medical Examiners Regulations, the EMG test being performed by a chiropractic physician must be personally supervised. Dr. Factor made no indication that he was physically present to personally supervise the EMG performed by the technician, Tiffany Borreau.

Finally, Respondent argues that there is no showing that Steven Factor, D.O. or Tiffany Borreau had privileges from Hudson Regional Hospital in violation of N.J.A.C. 8:43G-16.1, as noted above by Dr. Carmickle.

For the foregoing reasons, Respondent argues that the claim for benefits must be denied.

Respondent also provides prior DRP awards which it argues support its position.

Findings

After considering the arguments and documentation presented, I find that the Claimants have established by a preponderance of the evidence that they are entitled to reimbursement. In that regard, I am persuaded by the opinion of Dr. Cruz noting the distinction between diagnostic EMG testing and intraoperative monitoring. Dr. Cruz noted that the IONM EMG is performed for a different reason, in a completely different environment than diagnostic EMG, which is utilized to diagnose pathology. He noted that the IONM technician, in this case, Tiffany Borreau-Furr, CNIM, who was certified in neurophysiologic intraoperative monitoring, does not diagnose anything, but rather conducts electrical stimuli along nerve pathways that are in, or very near to the surgical site. The purpose of the intraoperative monitoring is to detect changes in baseline patterns that might delineate nerve interference or damage during the surgery. Dr. Cruz noted that the technician is constantly supervised by a physician, remotely in all cases. I find that the intraoperative monitoring was not a diagnostic needle EMG performed with the intent of establishing a diagnosis for the purpose of recommending a course of treatment. Accordingly, I do not find persuasive Respondent's argument that the services must be denied for violation of the cited regulations. I find that there is no prohibition or regulation which prevents the Claimants from performing the services in dispute; specifically, I find that the monitoring may be performed by a trained technician while being supervised remotely by a physician.

In addition, I find Respondent's argument regarding hospital privileges to be unpersuasive. I agree with Claimant that N.J.A.C. 8:43G-16.1 relates primarily to hospital staffing and Respondent fails to cite any specific portion of the regulation to support its argument that intraoperative monitoring technicians or off-site intraoperative monitoring interpreting physicians are required to have privileges at a hospital.

Respondent argued that should Claimants prevail, a 50% precertification penalty should apply to the services in dispute. As Claimants have not provided proof of precertification, I find that a 50% precertification penalty applies to both Claimants.

Based on the foregoing, Neurophysiologic Interpretive Specialist is awarded $2,809.23. Accurate Monitoring is awarded $2,422.49.

Therefore, the DRP ORDERS:

Disposition of Claims Submitted

1. Medical Expense Benefits: Awarded

Medical Provider	Amount Claimed	Amount Awarded	Payable To
Interstate Multi-Specialty Medical Group	$90,781.91	$90,163.09	Interstate Multi-Specialty Medical Group

The awarded amounts are subject to:
Deductibles
Co-payments
Medical fee schedule
Payments made
Policy limits

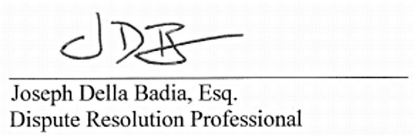
2. Income Continuation Benefits Not in Issue
3. Essential Services Benefits Not in Issue
4. Death Funeral Expense Benefits Not in Issue
5. Award of Interest Not in Issue

Attorney's Fees and Costs

I find that the Claimant prevailed but is not legally entitled to costs and fees because:
NJ PLIGA is not subjected to interest and attorney's fees and costs

THIS AWARD is rendered in full satisfaction of all claims and issues presented in the arbitration proceeding.

Entered in the State of New Jersey



Joseph Della Badia, Esq.
Dispute Resolution Professional

Date:08/26/19