American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

| | | |
|---|---|---|
| Westchester Medical Center (Applicant) | AAA Case No.<br>Applicant's File No. | 17-15-1008-4939 |
| - and - | | |
| Geico Insurance Company (Respondent) | Insurer's Claim File No.<br>NAIC No. | 0459330760101011 |

**ARBITRATION AWARD**

I, Ben Feder, 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: IP or assignor

1. Hearing(s) held on 10/27/2015 03:15 PM
   Declared closed by the arbitrator on 11/03/2015 00:11 AM

   Greggory Henig participated in person for the Applicant

   Regina Wilcox participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 21,928.82**, 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

   Whether Respondent's global denial is defective?

   Whether Applicant's medical services, performed from 10/20/14 through 10/22, were necessary emergency health services, in light of Respondent's denial and peer review based upon the IP's intoxication?

4. Findings, Conclusions, and Basis There for

   This case arises out of a motor vehicle accident which occurred on 10/19/14. The 34 year-old IP/driver was involved in a one-vehicle accident in which his car

struck a tree. Assignor was taken to Catskill Regional Medical Center and eventually airlifted to Westchester Medical Center (Applicant). The initial emergency room findings revealed 10 fractured ribs and deformity within the thoracic and lumbar spine. Several surgeries were subsequently performed. A blood toxicology test was performed and it revealed an ethanol concentration level of 190 mg/dl, which is well above the legal limit in the state of New York. In addition, the IP's urine toxicology was positive for benzodiazepine, cocaine, and opiates. Applicant seeks reimbursement for hospital services from 10/20/14 through 10/22/14. Respondent issued a global denial dated 12/3/14 stating that all No-Fault benefits are excluded to operators under the influence of drugs and or alcohol. Subsequently, Respondent issued a specific denial, dated 2/9/15, based upon a peer review by Dr. Sharahy. The specific denial goes on to state that the IP was stabilized after he was extubated on 10/20/14, and that all post-stabilization charges are denied.

If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary, the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. (See *A.B. Medical Services, PLLC v. Geico Insurance Co.,* 2 Misc. 3d 26 [App Term, 2nd & 11th Jud Dists 2003]; *Kings Medical Supply Inc. v. Country Wide Insurance Company,* 783 N.Y.S. 2d at 448 & 452; *Amaze Medical Supply, Inc. v. Eagle Insurance Company,* 2 Misc. 3d 128 [App Term, 2nd and 11th Jud Dists 2003]).

Initially, Applicant argues that Respondent's global denial is defective on its face, in that, Respondent may not deny the claim simply upon the basis of the IP's intoxication.

Section 5103(b)(2) of the Insurance Law, states that:

> An insurer may exclude from coverage required by subsection (a) hereof a person who: (2) Is injured as a result of operating a motor vehicle while in an intoxicated condition or while his ability to operate such vehicle is impaired by the use of a drug within the meaning of section eleven hundred ninety-two of the vehicle and traffic law; provided, however, that an insurer shall not exclude such person from coverage with respect to **necessary emergency health services** rendered in a general hospital, as defined in subdivision ten of section two thousand eight hundred one of the public health law, including ambulance services attendant thereto and related medical screening. Notwithstanding any other law, where the covered person is found to have violated section eleven

> hundred ninety two of the vehicle and traffic law, the insurer has a cause of action for the amount of first party benefits paid or payable on behalf of such covered person against such covered person. (emphasis added)

A circular letter was issued by the New York State Insurance Department on January 12, 2011 which states:

> For the purposes of compliance with Chapter 303, the Department interprets "necessary emergency health services" to mean services rendered to a person by or under the supervision of a physician, paramedic, or emergency medical technician to treat the onset of sudden pain or injury and to stabilize the person, provided the person is transported directly from the scene of the motor vehicle accident to the general hospital.

Respondent's general denial simply states "No-Fault Benefits are excluded to operators under the influence of drugs and/or alcohol." Respondent has not alleged that Applicant is not a general hospital, as defined in section 2801 of the Public Health Law. The global denial does not reference Applicant's services as being "not necessary emergency health services".

It well settled that a no-fault insurer is bound by the "four corners of the denial" and "must "stand or fall upon the defense upon which it based its refusal to pay." Todaro v. Geico General Insurance Company, 46 A.D.3d 1086, 848 N.Y.S.2d 393 (3rd Dept. 2007). Moreover, a denial must "promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated." General Accident Insurance Company v. Cirucci, 46 N.Y.2d 862, 414 N.Y.S.2d 512 (1979).

Since Respondent's denial did not state that the services provided by Applicant were not necessary emergency health services, I find that Respondent's denial is fatally defective. See St. Vincent's Hospital & Medical Center v. New Jersey Manufacturers Insurance Company, 82 A.D.3d 871, 918 N.Y.S.2d 356 (2nd Dept. 2011). Respondent cannot, now, rely on the specific denial based upon the peer review.

In *State Farm v. Domotor*, 266 A.D.2d 219, 697 N.Y.S.2d 348 (2nd Dept. 1999), Applicant argued that the general denial or "disclaimer of coverage" excused Applicant from further compliance (i.e. responding to the verification requests). The Court there held that an insurance carrier may not, after repudiating liability, create grounds for its refusal to pay on additional or different grounds. Rather, the insurance carrier must "stand or fall upon the defense upon which it based its refusal to pay".

In as much as Respondent issued a global denial informing Applicant that it was disclaiming coverage due to the intoxication of the IP, Domotor compels me to find that the insurer cannot change their denial basis to be that the services, provided by this Applicant, were not necessary emergency health services. That is a completely different basis of denial.

However, assuming arguendo, that Respondent could rely on the specific denial, I would find that Applicant did provide necessary emergency health services and would be entitled to reimbursement.

When an insurer relies upon a peer review report to demonstrate that a particular service was not medically necessary, the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory. As per the holding in Jacob Nir, M.D. v.Allstate Insurance Co., 7 Misc.3d 544 (2005), the peer reviewer must establish a factual basis and medical rationale to support a finding that the services were not medically necessary, including setting forth generally accepted standards in the medical community. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden to prove that the services were not medically necessary. CityWide Social Work & Psychological Services, PLLC v. Travelers Indemnity Co., 3 Misc.3d 608, 777 N.Y.S.2d 241 (N.Y.Civ. Ct. Kings Co. 2004).

Dr. Sharahy's peer review discusses the IP's intoxication, as well as, the drugs found in the IP's urine toxicology. It is uncontroverted that the IP was operating the motor vehicle with a blood alcohol level well above the legal limit. Dr. Sharahy opines that the IP was "stabilized from a hemodynamic point of view on 10/20/14 after he was extubated". Dr. Sharahy does not expand on this point. Nonetheless, the inference is that the IP was no longer receiving necessary emergency health benefits at Applicant's facility after being extubated.

Every peer review requires individual scrutiny to determine whether the burden should be shifted back to the claimant to submit contrary expert proof. If the claimant can demonstrate, through references to the medical records or otherwise, that the peer review doctor's opinion lacks a sufficient basis and/or medical rationale because it is conclusory, or because it fails to address essential factual issues or is based upon disputed or apparently incorrect facts, the insurer has fallen short of its burden of proof. Novacare Medical P.C. v. Travelers Property Casualty Ins. Co., 31 Misc.3d 1205(A), 927 N.Y.S.2d 817 (Table), 2011 N.Y. Slip Op. 50500(U) at 4, 2011 WL 1226956 (Dist. Ct. Nassau Co., Michael A. Ciaffa, J., Apr. 1, 2011). After such scrutiny, the burden does not shift back to Applicant, as in this case, to submit contrary expert proof.

Upon a thorough review of the evidence submitted and position statements presented at the hearing, it is this Arbitrator's determination that Respondent's expert failed to explain why Applicant's medical treatment did not fall under the definition of necessary emergency medical care. The peer review is not supported by factual evidence. No medical authority was provided that supports the position that extubation is deemed the end of necessary emergency medical care. I find no basis for Dr. Sharahy's statements other than her own opinion on the matter. I find that the peer review report is insufficient to meet Respondent's burden of proof as referenced above, the burden of which shifts to Respondent once Applicant has established a prima facie case.

As the burden of proof does not shift back to the Applicant, there is no need to discuss Applicant's evidence which includes an affidavit of a medical coding expert and an orthopedic medical review by Dr. Benatar.

Accordingly, after a careful review of the records and consideration of the parties' oral arguments, I find as a matter of fact that Applicant met its burden of establishing a prima facie case and Respondent failed to rebut it with evidence that the services provided by Applicant were not necessary emergency medical care. I therefore find for the Applicant. Reimbursement as requested is due and owing herein. This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

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.

| | Amount Claimed | Amount Awarded |
|---|---|---|
| Medical | $ 21,928.82 | $ 21,928.82 |
| TOTAL | $ 21,928.82 | $ 21,928.82 |

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 03/16/2015 12:03 PM, which is a relevant date only to the extent set forth below.)

Interest runs from the filing date for this case until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty day month.

C. Attorney's Fees

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

After calculating the sum total of the first-party benefits awarded in this arbitration plus the interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20% of that sum total, subject to a minimum of $60 and a maximum of $850. See, 11 NYCRR 65-4.6 (c) and (e). However, if the benefits and interest awarded thereon is equal to or less than the Respondent's written offer during the conciliation process, the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6 (b). For cases filed after February 4, 2015, there is no minimum fee and a maximum fee of $1360.00.

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 New York
SS :
County of NASSAU

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

11/03/2015
(Dated)

Ben Feder

**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:**
487e72ac924fb777899c534c11edac1d

**Electronically Signed**

Your name: Ben Feder
Signed on: 11/03/2015