

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Dassa Orthopedic Medical Services P.C.  
(Applicant)

- and -

Geico Insurance Company  
(Respondent)

AAA Case No. 17-16-1033-7114  
Applicant's File No. TM-16-1566  
Insurer's Claim File No. 0415825240101013  
NAIC No. 35882

**ARBITRATION AWARD**

I, Evelina Miller, 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: SS

1. Hearing(s) held on 05/23/2017  
Declared closed by the arbitrator on 05/23/2017

Naomie Jean-Philippe Esq from Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara, Wolf LLP participated in person for the Applicant

Kevin Smith from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 11,130.48**, 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 Applicant established entitlement to No-Fault compensation for fees associated with right knee arthroscopy performed on Assignor.

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

Whether Applicant properly billed for services provided under the New York Workers' Compensation fee schedule, or whether Respondent was able to reach its burden of coming forward with competent evidentiary proof to support its fee schedule defenses

#### 4. Findings, Conclusions, and Basis Therefor

Applicant was represented by Naomie Jean-Philippe Esq., who presented oral arguments and relied upon documentary submissions. Kevin Smith, appeared by phone on behalf of Respondent and presented oral arguments and relied upon documentary submissions I have reviewed the submissions contained in MODRIA. These submissions are the record in this case.

The disputes arise from the underlying automobile accident of June 22, 2015, in which the Assignor (SS), a 41-year-old male was a restrained driver. After the accident patient was taken to Jacobi Medical Center where he was treated and released. Thereafter patient sought private medical attention and was eventually evaluated by Dr. Gabriel Dassa with complaints of neck and back pain. Patient was recommended to undergo conservative care. Eventually patient was recommended to undergo arthroscopy of the right knee. The bills in dispute are for the arthroscopy of the right knee performed on the patient on 9/28/15.

I find that Applicant establishes its prima facie showing of entitlement to recover first-party no-fault benefits by submitting evidentiary proof that the prescribed statutory billing forms, setting forth the fact and amount of the loss sustained, had been mailed and received and that payment of no-fault benefits were overdue. See *Mary Immaculate Hospital v. Allstate Insurance Co.*, 5 A.D.3d 742, (2d Dept., 2004).

Applicant's proof is also in Respondent's denials, which acknowledged receipt of the bill. Since Applicant establishes its prima facie showing of entitlement to recover first-party no-fault benefits, the burden then shifts to the Respondent to demonstrate a lack of medical necessity for the items at issue. See, *Citywide Social Work & Psychological Services, PLLC v. Allstate Ins. Co.*, 8 Misc 3d 1025 A (2005).

For dates of service of 9/28/15 Respondent issued timely denial based on an IME of Dr. Kiernan and Dr. Lyons performed on 8/26/15. As a result of the IMEs it was determined that there is no medical necessity for further medical services. As a result all no-fault benefits were terminated effective 9/10/15.

#### **Medical Necessity:**

A denial premised on a lack of medical necessity must be supported by competent evidence such as an independent medical examination, a peer review or other proof which sets forth a factual basis and a medical rationale for denying the claim. *Healing Hands Chiropractic, P.C., v. Nationwide Assur. Co.*, 5 Misc., 3d 975, 787 N.Y.S. 2d 645 (Civ.Ct., New York County, 2004); *King's Med. Supply Inc. v. Country Wide Ins. Co.*, 5 Misc. 3d 767, 783 N.Y.S. 2d 448.

Once Respondent submits an IME report or peer review that has a sufficient factual basis and medical rationale, then the courts have routinely found that Respondent has established its prima facie defense that the disputed medical service is medically

unnecessary. *A Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co.*, 16 Misc.3d 131(A), 841 N.Y.S.2d 824 (Table, Text in WESTLAW), Unreported Disposition, 2007 WL 1989432, 2007 N.Y. Slip Op. 51342(U) (N.Y. Sup. App. Term Jul 03, 2007). See also, *Amaze Medical Supply Inc. v. Eagle Insurance Company*, 2003NY Slip Op 51701 (U), 2 Misc.3d. 128 (App. Term 2d & 11 Dist.-2003).

**IME by Dr. Howard Kiernan M.D.**

On August 26, 2015, Dr. Howard Kiernan M.D. performed an IME evaluation on behalf of the Respondent regarding the medical necessity of orthopedic treatment performed on Assignor. The Claimant presented with subjective complaints of neck pain, back pain and right knee pain.

Dr. Kiernan reviewed medical records, and performed a medical evaluation of the Assignor.

Examination of the Cervical Spine revealed no tenderness or muscle spasms. Range of motion in left rotation was decreased.

Examination of the shoulders revealed normal ranges of motion. There was no instability noted. There was no impingement sign.

Examination of the Lumbar spine revealed normal ranges of motion. There were no tenderness or muscle spasms noted.

Examination of the knees revealed normal ranges of motion. There were no signs of meniscal damage or ligament instability.

Neurological examination revealed equal muscle strength. Reflexes were -2 and symmetrical. There were no sensory deficits. Spurling's test is negative. Straight leg raising test is negative.

**IME by Dr. Caroline Lyons MS, L.Ac.**

On August 26, 2015, Dr. Caroline Lyons performed an IME evaluation on behalf of the Respondent regarding the medical necessity of acupuncture treatment performed on Assignor. The Claimant presented with subjective complaints of neck pain, back pain and right knee pain.

Dr. Lyons reviewed medical records, and performed a medical evaluation of the Assignor.

Examination of the Cervical Spine revealed no tenderness noted. Range of motion of the cervical spine was normal. Acupuncture evaluation was normal.

Examination of the Lumbar spine revealed normal ranges of motion. There muscle spasms noted. Acupuncture evaluation was normal.

Examination of the right knee revealed no swelling, or redness, or increase warmth. There was mild crepitus present. Range of motion of the right knee was normal. There was no tenderness noted. Orthopedic tests were negative.

In order for an applicant to prove that the disputed expenses were medically necessary, it must meaningfully refer to, or rebut, the conclusions set forth in the IME reports.

*Ortho-Med Surgical Supply, Inc. v. Progressive Cas. Ins. Co.*, 2012 NY Slip Op 50149(U) (App Term 2d, 11th & 13th Jud Dists Jan. 24, 2012); *Yklik, Inc. v. Geico Ins. Co.*, 2010 NY Slip Op. 51336(U) (App Term 2d, 11th & 13th Dists. July 22, 2010); *High Quality Medical, P.C. v. Mercury Ins. Co.*, 2010 N.Y. Slip Op. 50447(U) (App Term 2d, 11th & 13th Dists. Mar. 10, 2010); *Pan Chiropractic, P.C. v. Mercury Ins. Co.*, 24 Misc.3d 136(A), 2009 N.Y. Slip Op. 51495(U) (App Term 2d, 11th & 13th Dists. July 9, 2009).

A letter of medical necessity sworn to by a provider who had examined assignor, along with other medical documentation, may be sufficient to rebut the IME and establish the medical necessity of the services rendered. See *Quality Psychological Servs., P.C. v. Mercury Ins. Group*, 2010 NY Slip Op 50601(U) (App Term 2d Dept., April 2, 2010). See also *Neomy Med., P.C. v. Geico Ins. Co.*, 2012 NY Slip Op 50145(U) (App Term 2d, 11th & 13th Jud Dists Jan. 24, 2012); *Vinings Spinal Diagnostic, P.C. v. Geico Gen. Ins. Co.*, 2010 NY Slip Op 51897(U) (App Term 2d Dept., Nov. 8, 2010) (an affidavit from a chiropractor "meaningfully referred to" the peer and "sufficiently rebutted the conclusions set forth therein"); *Park Slope Med. & Surgical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co.*, 22 Misc.3d 141(A), 2009 NY Slip Op 50441(U) (App Term 2d, 11th & 13th Jud Dists 2009).

#### **Rebuttal by Applicant:**

Applicant submits a rebuttal by Dr. Gabriel Dassa D.O. who was the treating provider in this case. He states that the patient sustained a right tear of medial meniscus and sprain of the MCL and ACL. Patient reported functional pain especially when getting up from a seated position at an examination. He also reported buckling of his right knee.

An MRI of the Right knee was performed on 7/17/15. It revealed MCL sprain but no tears; ACL strain but no tears; Popliteal tendon tendinosis condromalacia type II; Vertical tear seen in the body of the medial meniscus.

Dr. Dassa states that because of persistent and worsening symptoms of the patient's right knee and failure to respond to conservative therapy, he recommended arthroscopic surgical intervention. Dr. Dassa goes on to say that arthroscopic surgery can help diagnose the pain associated with meniscal tears and is one of the most predominant forms of treatment when the pain is severe and occurs frequently. If the menisci are damaged, the knee can become very unstable and arthritis may result. Surgery may provide the best alternative to preserving the knee from further damage and later problems.

The patient's failure to respond to extensive non-surgical treatment warranted the need for invasive treatment. His complaints, physical findings, and MRI findings and

operative findings correlated well document the series of internal derangement of his right knee. Based on the above Dr. Dassa concludes that there was medical necessity for the right knee arthroscopy.

**Addendum by Dr. Howard Kiernan:**

Respondent submits an Addendum by Dr. Howard Kiernan to the rebuttal by Dr. Dassa. He cites to Official Disability Guidelines, physical therapy versus surgery which states: "...Researchers at 7 major universities and orthopedic surgery centers around the United States assigned 351 people with arthritis and meniscal tears to get either surgery or physical therapy. And after 6 months both groups had similar rates of functional improvement and pain scores. These results suggest that physical therapy may be an appropriate first option for many patient with osteoarthritis and meniscal tears and it may be possible to reserve surgery for those who do not benefit from physical therapy...Arthroscopic surgery for osteoarthritis of the knee offers no added benefit to optimize physical therapy and medical therapy, according to the results of a single center RCT reported in the New England Journal of Medicine.

Dr. Kiernan concludes that although Dr. Dassa seems to feel that a person with a torn meniscus needs an operation, he stand alone in that view. That is simply not supported by literature.

**Conclusion:**

After careful consideration evidence submitted and arguments presented at the hearing I find the following. The IME of Dr. Kiernan and Dr. Lyons revealed that the patient presented with subjective complaints, but no positive objective findings. Rebuttal by Dr. Dassa noted that the patient was experiencing subjective complaints as well as positive objective findings specifically pain and buckling of the right knee. Due to failure of conservative treatment, the patient's complaints as well as MRI findings, Dr. Dassa concluded that there was medical necessity for arthroscopy of the right knee. In his addendum Dr. Kiernan cites to medical literature which states that essentially in most cases tested the results with physical therapy in patients with torn meniscus were the same as the results in patients who had surgery performed. However, Dr. Dassa had stated that the patient failed to respond to the course of physical therapy and therefore he recommended surgery. In light of the foregoing, I find that Respondent has failed to establish its defense. The presumption of medical necessity which attaches to Applicant's claim has not been successfully challenged.

Accordingly, Applicant's claim for reimbursement is granted.

**Fee Schedule:**

The rates charged by Applicant must be in accordance with Insurance Law § 5108, as the charges for services rendered "shall not exceed the charges permissible under the schedules prepared and established by the chairman of the Workers Compensation Board for Industrial Accidents, except where the insurer or arbitrator determines that unusual procedures or unique circumstances justify the excess charge."

In addition, § 5108 (c) states that, "no provider of health services... may demand or request any payment in addition to the charges authorized pursuant to this section."

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct. Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curiam, 2006).

Effective April 1, 2013 11 NYCRR 65-3.8(g)(1) has been amended so that the application of the New York State Worker's Compensation fee schedule is no longer a precludable defense and no payment is due on those claims in excess of the fee schedule. Per 11 NYCRR 65-3.8(g), where the services were rendered after April 1, 2013, a defense of excessive fees is not subject to preclusion Surgicare Surgical Associates v. National Interstate Ins. Co., Misc.3d., N.Y.S.3d., 2015 N.Y. Slip Op. 25338 (App. Term 1st Dept. Oct. 8, 2015), aff'g, 46 Misc.3d 736, 997 N.Y.S.2d 296 (Civ. Ct. Bronx Co. 2014) (New Jersey fee schedule). The insurer is entitled to reduce the bills to the proper fee schedule amount.

For the arthroscopic surgery of the right knee Applicant billed for the services performed as follows:

29876-59 - \$3,119.27

29877 - \$2,943.23

29880 - \$3,311.24

29884 - 59- \$1,756.74

Total : \$11,130.48

Respondent reimbursed Applicant as follows:

29876-59 - \$1,792.29

29877 - \$0

29880 - \$3,311.24

29884 - 59- \$1,317.86

Total: \$6,421.39

As an explanation, Respondent states the following:

1. Multiple procedures are reimbursed as follows: the procedure with the largest dollar amount is reimbursed as 100% of scheduled value, and subsequent procedures performed on the same day are reimbursed at 50% of the scheduled value.
2. It is noted that the provider has submitted CPT code 29877. Per CPT 2014 guidelines for CPT code 29877, "when performed with arthroscopic meniscectomy, see 29880 or 29881." The services described by CPT code 29877 are inclusive components of the services described by CPT code 29880, described as "arthroscopy, knee surgical; with meniscectomy (medial and lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartments, when performed.

Applicant does not submit a rebuttal to Respondent's argument regarding the applicable fee. However, Applicant's attorney argued at the hearing that since Respondent did not address the fact that Applicant billed with modifier 59, its fee schedule defense cannot be sustained.

**Conclusion:**

After reviewing all the evidence submitted and arguments presented at the hearing I find the following. In regards to code 29877 I find that Respondent demonstrates by competent evidentiary proof that Applicant's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules is sustained. Therefore, I find that Applicant is not entitled to reimbursement of code 29887 in the amount of \$2,943.23.

In regards to codes 29876-59 - \$1,792.29 and code ,29884 - 59- \$1,317.86, I find that Respondent's fee schedule defense cannot be sustained as Respondent did not address the fact that Applicant billed with a modifier 59. Respondent failed to discuss why it was inappropriately used.

Therefore I find that Applicant is entitled to reimbursement as follows:

29876-59 - \$3,119.27

29877 - \$0

29880 - \$3,311.24

29884 - 59- \$1,756.74

**Total : \$8,187.25**

5. Optional imposition of administrative costs on Applicant.  
Applicable for arbitration requests filed on and after March 1, 2002.

I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**

- ☐ The policy was not in force on the date of the accident
- ☐ The applicant was excluded under policy conditions or exclusions
- ☐ The applicant violated policy conditions, resulting in exclusion from coverage
- ☐ The applicant was not an "eligible injured person"
- ☐ The conditions for MVAIC eligibility were not met
- ☐ The injured person was not a "qualified person" (under the MVAIC)
- ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
- ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Status
	<b>Dassa Orthopedic Medical Services P.C.</b>	<b>09/28/15 - 09/28/15</b>	<b>\$11,130.48</b>	<b>Awarded: \$8,187.25</b>
<b>Total</b>			<b>\$11,130.48</b>	<b>Awarded: \$8,187.25</b>

- B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 05/16/2016, which is a relevant date only to the extent set forth below.)



Since the motor vehicle accident occurred after April 5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30 day month. 11 NYCRR 65-3.9(a). In accordance with 11 NYCRR 65-3.9c, interest shall be paid on the claims totaling \$8,187.25 from the date the arbitration was commenced.

C. Attorney's Fees

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

Respondent shall pay Applicant an attorney's fee upon the amount awarded plus the interest, as calculated in section "B" above, and in accordance with 11 NYCRR 65-4.6(e), i.e., 20 percent of the amount of first party benefits, plus interest thereon. The minimum attorney's fee payable shall be in accordance with 11 NYCRR 65-4.6c. For cases filed after February 4, 2015, there is no minimum attorney's fee but there is a maximum fee of \$1,360.00. However, if the benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b)."

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

07/02/2017

(Dated)

Evelina Miller

**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:**

8cf2bace3e6d1ef17395fc2df07d0c5f

### **Electronically Signed**

Your name: Evelina Miller  
Signed on: 07/02/2017