American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Advantage Physical Therapy of NYC, PC , Alexander Kolesnikov Medical, PC (Applicant)	AAA Case No.	17-16-1032-8981
	Applicant's File No.	
	Insurer's Claim File No.	0197965580101043
- and -	NAIC No.	22063
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Dinsmore Campbell, 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: Claimant

1. Hearing(s) held on 07/21/2017
   Declared closed by the arbitrator on 07/21/2017

   Hersh Jakubowitz, Esq. from Law Offices of Hersh Jakubowitz PLLC participated in person for the Applicant

   Keith Zucker, Esq. from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,805.13**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated that the applicant established its prima facie case of entitlement to No-Fault benefits and that the respondent's NF-10/Denial of Claim forms were timely issued in accordance with 11 NYCRR 65-3.8(a)(1).

3. Summary of Issues in Dispute

   The claimant, a 48 year-old male, was involved in a motor vehicle accident on 7/6/13, as a restrained driver. Thereafter, the claimant sought medical attention for the injuries

sustained. This dispute arises from claims for services rendered on 8/7/13 through 11/12/13. Respondent denied the claims based on an IME conducted on 10/30/13 by Dr. Frank D. Oliveto; and its assertion that the applicant billed in excess of the Fee Schedule.

The undersigned notes that there are two providers in this matter:

- Alexander Kolesnikov Medical, PC ("AK Medical")-contemplating a claim for range of motion and manual muscle testing in the amount of $492.25, provided on 8/29/13, denied on the basis that fees are in excess of the fee schedule; a claim for range of motion and manual muscle testing in the amount of $405.05, provided on 10/8/13, denied on the basis that fees are in excess of the fee schedule; a claim for range of motion and manual muscle testing in the amount of $565.09, provided on 11/5/13, denied on the basis of an IME.

- Advantage Physical Therapy of NYC PC (" Advantage")-contemplating claims for physical therapy services provided 8/7/13 through 10/30/13 in the amount of $154.58 denied on the basis of the 8 unit rule; a claim for physical therapy services provided on 11/5/13 through 11/12/13, in the amount of $188.16, denied on an IME.

4. Findings, Conclusions, and Basis Therefor

This case was decided on the submissions of the parties as contained in the Electronic Case Folder maintained by the American Arbitration Association and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in the ECF for both parties and make my decision in reliance thereon.

Fee Schedule.

With respect to the claims for range of motion and manual muscle testing provided by AK Medical, in the amount of $897.30 provided on 8/29/13 and 10/8/13, the respondent contends that the applicant's bills are in excess of the Worker's Compensation Fee Schedule. However, the 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, 12 Misc.3d 172, 8222 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 an Applicant's claims were in excess of the appropriate fee schedules, Respondent'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).

After review of the documents contained in the ECF and in consideration of the arguments made by the parties at the hearing, the undersigned finds that the respondent has failed to establish its fee schedule defense and the applicant is entitled to full

reimbursement of those claims that were reduced. Indeed, the fee schedule reductions asserted by the respondent are unsupported by an affidavit from an expert, or any other documentary evidence.

With respect to claims for physical therapy services provided 8/7/13 through 10/30/13 in the amount of $154.58 by Advantage, the respondent denied the claims based on the 8 unit rule. Indeed, the respondent denied the claims based upon Physical Medicine Ground Rule 11, and Ground Rule 3 in the Chiropractic chapter which provides that "when multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 8.0 RVUs or the amount billed, whichever is less."

A review of the instant claims and the aforementioned ground rules reveal that the CPT codes billed by the applicant are subject to this rule.

The respondent contends that prior to its receipt of the applicant's claims, it previously reimbursed another provider for the same dates of service at issue and for modalities subject to the 8-unit rule.

The applicant does not dispute that another provider was paid, but argued that the 8-unit rule does not apply in this case as it treated a different body part.

I disagree with the applicant's interpretation. The 8-unit rule was intended to limit reimbursement of modalities rendered on the same date. Based upon a plain reading of the 8-unit rule, all modalities rendered are subject to the provision. The Ground Rule makes no distinction with regard to the provider or the body parts treated. In fact, when an insurer establishes that it has already paid for 8 units of physical medicine procedures and modalities listed in the Ground Rule, it can assert its prior payment as a limitation when another provider bills for a physical medicine procedure performed on the same day. See Liberty Chiropractic, P.C. v 21st century Ins. Co., 2016 N.Y. Slip Op. 51409 (App. Term 2nd, 11th and 13th Jud. Dists. 2016).

As such, the undersigned finds that the respondent has submitted sufficient, credible evidence that it properly reimbursed the applicant for the modalities pursuant to the 8 unit rule. No additional payment is due.

Accordingly, the respondent's NF-10\Denials of treatment are sustained and these claims are denied.

Medical Necessity.

With respect to the claim for range of motion and manual muscle testing provided by AK Medical in the amount of $565.09, rendered on 11/5/13; and the claim for physical therapy services provided by Advantage in the amount of $188.16, rendered on 11/5/13 through 11/12/13, the respondent asserts a lack of medical necessity defense. However, a denial premised on lack of medical necessity must be supported by competent

evidence such as an independent medical examination, peer review or other proof which sets forth a factual basis and medical rational for denying the claim. See, Healing Hands Chiropractic, P.C. v. Nationwide Assur. Co., 5 Misc3d 975 (2004).

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 2009 NY Slip Op 00351 (App Div 2d Dep't., Jan. 20, 2009); Channel Chiropractic, P.C. v. CountryWide Ins. Co., 2007 Slip Op 01973, 38 A.D.3d 294 (1st Dep't. 2007); Bronx Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co., 2007 NY Slip Op 27427, 17 Misc.3d 97 (App Term 1st Dep't., 2007), such as by a qualified expert performing an independent medical examination, conducting a peer review of the injured person's treatment, or reconstructing the accident. Id.

The trial courts have held that a peer review report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. See generally, Nir v. Allstate Ins. Co., 7 Misc.3d 544, 547, 796 N.Y.S.2d 857, 860 (Civ. Ct. Kings Co. 2005); See also, All Boro Psychological Servs. P.C. v. GEICO, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012).

In support of its contention that the services were medically unnecessary, the respondent relies upon the IME of Dr. Oliveto conducted on 10/30/13 with an effective cutoff date of 11/5/13. At the time of the examination, the claimant was presented with subjective complaints of pain in her neck, mid back, low back, right shoulder, right elbow, right wrist, right hand, right knee and headaches.

However, Dr. Oliveto concludes that there was no evidence of an orthopedic disability and maintains that the claimant was able to perform the duties of her occupation without restrictions or limitations and was capable of performing all activities of daily living. Although he concedes that there was some tenderness and decreased range of motion noted, he insists that the claimant reached an endpoint regarding further orthopedic treatment. He states in pertinent part:

> Based on my examination, no treatment is needed from an orthopedic viewpoint. There is no need for physical therapy and further treatment would be considered excessive. There is no indication for diagnostic testing or massage therapy. It is my opinion that there is no need for household help, special supplies, or special transportation. There is no need for surgery or injections.

The applicant disagrees and urges the undersigned to consider the numerous positive findings noted in Dr. Oliveto's report. Indeed, Dr. Oliveto noted minimal tenderness to palpation over the dorsal muscles and limited range of motion in the thoracic spine. Regarding the lumbar spine, there was minimal tenderness noted in the paralumbar muscles on palpation, as well as limited range of motion. Dr. Oliveto also noted tenderness in the right shoulder, left shoulder and right knee.

The applicant also provided the claimant's contemporaneous reports which noted positive findings.

After reviewing the pertinent record, and in consideration of the parties' oral arguments, the undersigned find that the applicant was able to refute the IME findings. Although the IME doctor recommended no further rehabilitative treatment, his examination and the treatment reports revealed positive findings, which I find to be inadequately reconciled. Coupled with the claimant's subjective complaints of pain, the undersigned finds that the respondent failed to establish, prima facie, its lack of medical necessity defense.

As such, the applicant is awarded the sum of $1650.55. (Advantage-$188.16; AK Medical-$1462.39)

Any further issues raised in the record are held to be moot and/or waived insofar as not raised at the time of the hearing.

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.

Medical		From/To	Claim Amount	Status
	Alexander Kolesnikov Medica MD	**08/29/13 - 11/05/13**	**$1,462.39**	**Awarded: $1,462.39**
	Advantage Physical Therapy of NYC, PC	**08/07/13 - 11/12/13**	**$342.74**	**Awarded: $188.16**
Total			**$1,805.13**	**Awarded: $1,650.55**

B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 04/22/2016, which is a relevant date only to the extent set forth below.)

The insurer shall compute interest and pay Applicant the amount of interest computed from the filing date as indicated above at the rate of 2% per month, simple, not compounded, calculated on a pro rata basis using a thirty day month and ending with the date of payment of the award.

C. Attorney's Fees

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

Effective to filings on or after February 6, 2015, this case is subject to the provisions as to attorney fee promulgated in the Sixth Amendment to 11 NYCRR 65-4(Insurance Regulation 68-D). As amended, 11 N.Y.C.R.R. §65-4.6(d) reads: "For all other disputes subject to arbitration or court proceedings, subject to the provisions of subdivision (a) of this section, the attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant per arbitration or court proceeding, subject to a maximum fee of $ 1360. If the nature of the dispute results in an attorney's fee that could be computed in accordance with the limitations prescribed in both subdivision (c) and this subdivision, the higher attorney's fee shall be payable."

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

08/05/2017
(Dated)

Dinsmore Campbell

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:
4714c971230773a29b1c7062e3449ffa

Electronically Signed

Your name: Dinsmore Campbell
Signed on: 08/05/2017