

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Advanced Medical Concepts PC
(Applicant)

- and -

American Transit Insurance Company
(Respondent)

AAA Case No. 17-16-1031-9451

Applicant's File No. 1245-70

Insurer's Claim File No. 78169608

NAIC No. 16616

ARBITRATION AWARD

I, Bryan Hiller, 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: Assignor

1. Hearing(s) held on 10/03/2017
Declared closed by the arbitrator on 10/03/2017

Joseph Giordano, Esq. from Lewin & Baglio LLP participated in person for the Applicant

Racquel Williams, Esq. from American Transit Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,400.51**, 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 is entitled to reimbursement for the lumbar epidural and facet joint injections performed on Assignor between August 12, 2015 and September 8, 2015 in connection with the injuries allegedly sustained in a motor vehicle accident on April 17, 2015 in light of the Respondent's Peer Review performed by Dr. Robert Pick on May 4, 2015 stating that the service were not medically necessary?

Whether Respondent properly reduced/denied payment for dates of service August 12, 2015 through September 8, 2015 lumbar epidural and facet joint injections based on a fee schedule defense?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement, along with interest and counsel fees, under the No-Fault Regulations, for lumbar epidural and facet joint injections performed between August 12, 2015 and September 8, 2015 in connection with injuries allegedly sustained by Assignor in a motor vehicle accident on April 17, 2015. The injections at issue were denied following Peer Review by Dr. Robert Pick done at Respondent's behest after which injections and related services and their related costs were deemed not medically necessary. Additionally, Respondent submitted a fee schedule audit stating that the Applicant billed over the fee schedule for the billed services. All denials were timely. This decision is based upon the written submissions of counsel for the respective parties as well as oral argument at the October 3, 2017 hearing. I have reviewed the documents contained in the Record as of the date of the hearing.

This arbitration arises out of medical treatment for the Assignor, a then 32 year old male front seat passenger, was involved in an automobile accident on April 17, 2015. Following the accident, Assignor was taken via ambulance to the emergency room at Harlem Hospital where he was evaluated, treated and released the same day. Due to a persistence of symptoms following the accident, Assignor came under the care of multiple providers for conservative care. Ultimately, Assignor was referred to Applicant Advanced Medical Concepts PC for injection therapy. The lumbar epidural and facet joint injections between August 12, 2015 and September 8, 2015 at issue were performed at Applicant Advanced Medical Concepts PC's facility and the notes related to that treatment are attached to the Record.

Applicant establishes its prima facie entitlement to no-fault benefits by proving the submission of statutory claim forms, setting forth the fact and the amount of the loss sustained, and that payment of no-fault benefits was overdue (see Insurance Law § 5106 [a]; *Mary Immaculate Hosp. v Allstate Ins. Co.*, 5 AD3d 742 [2d Dept 2004]). The documents merit out that the Applicant has established its prima facie entitlement to benefits based on the valid submission of the bill and that the Respondent preserved its defense by issuing a timely denial.

Upon proof of a prima facie case by the applicant, the burden shifts to the insurer to prove that the services were not medically necessary (see *A.B. Medical Services, PLLC v. Lumbermens Mutual Casualty Company*, 4 Misc.3d 86, 2004 N.Y. Slip Op. 24194 (App. Term 2d and 11th Jud. Dists. 2004)).

The Respondent must establish a detailed factual basis and a sufficient medical rationale for its asserted lack of medical necessity (see *Delta Diagnostic Radiology, P.C. v. Progressive Casualty Ins. Co.*, 21 Misc.3d 142A, 880 N.Y.S.2d 223 (2nd Dept. 2008)). Additionally, it must be proven that said rationale is supported by evidence of the generally accepted medical/professional practices (see *Prime Psychological Servs., P.C. v. Progressive Cas. Ins. Co.*, 24 Misc.3d 1244A, 901 N.Y.S.2d 902 (Civ. Ct. Richmond Cty. 2009)). Once the Respondent makes a sufficient showing to carry its burden of coming forth with evidence of lack of medical necessary, the Applicant must rebut it

(see *A. Khodadadi Radiology, P.C. v. NY Central Mutual Fire Insurance*, 16 Misc.3d 131(A), 841 N.Y.S.2d 824 (2007)). As a general rule, reliance on rebuttal documentation will be weighed in light of the documentary proofs and the arguments presented at the arbitration. Moreover, the case law is clear that a provider must rebut the conclusions and determinations of the IME/Peer doctor with his own facts (see *Park Slope Medical and Surgical Supply, Inc. v. Travelers*, 37 Misc.3d 19 (2012)).

To support their position, the Respondent submitted a denial based upon the peer review report of Dr. Robert Pick dated November 10, 2015. Dr. Pick argued that there was no clinical evidence presented by the treating physician to substantiate the medical necessity for the injections to the lumbar spine. Dr. Pick noted that there was no evidence that the physiological and neurological condition was worsening despite a course of conservative treatment, which would lead to potential injection therapy. Lastly, Dr. Pick noted that there were no EMG-NCV's done to establish the presence of radiculopathy which can be treated with the subject injections. As such, Dr. Pick concluded that the injection therapy between August 12, 2015 and September 8, 2015 was not medically necessary.

Initially, Applicant's counsel argued that the peer review of Dr. Pick should be insufficient to shift the burden to the Applicant based on the fact that Dr. Pick has recently been in news articles speaking about fraudulent behavior he participated in with respect to IMEs. This article is complete hearsay as the EUO testimony and transcript has not been provided at this time. While this Arbitrator reserves his right to make further determinations on Dr. Pick's behavior and effectiveness, as presented here, Applicant has failed to substantiate any claims of fraudulent behavior.

Secondly, Applicant submitted a rebuttal from the performing physician Dr. Daniel Khaimov dated March 20, 2017 in response to the peer review. Dr. Khaimov outlined the course of treatment the Assignor underwent prior to the injection therapy as well as the findings of the lumbosacral MRI which showed disc herniations at the L5-S1 level touching the thecal sac with neural foraminal narrowing and rudimentary disc space at S1-S1. Dr. Khaimov pointed to the lack of response to conservative treatment to establish the necessity for the injections. Specific to the Assignor, Dr. Khaimov noted the lower back pain radiating to the right lower extremity with tenderness, muscle spasm, decreased range of motion and positive straight leg raise test despite several months of conservative treatment. Dr. Khaimov discussed the efficacy of the injections provided in relations to the findings of the examinations of the Assignor. Based on the significant examination and MRI findings and lack of success of conservative treatment, Dr. Khaimov argued that the only way to treat the Assignor's injury was with injection therapy.

Comparing the relevant evidence presented by both parties against each other and the above referenced medical necessity standard, I find the Applicant is entitled to reimbursement for the treatment provided to the Assignor. I find the rebuttal to the peer review sufficient to meet the Applicant's burden in establishing the medical necessity of the treatment after the Respondent's peer review shifted the burden. The rebuttal meaningfully refer to and rebut the conclusions set forth in the peer review report (see *High Quality Medical, P.C. v. Mercury Ins. Co.*, 26 Misc.3d 145(A), 2010 N.Y. Slip.Op.

50447(U)(Sup. Ct. App. Term 2nd Dept 2010)). Specifically, in this matter, Dr. Khaimov thoroughly addressed the significant lumbar pathology on the MRI examination and the lack of success of conservative treatment that was both acute and directly related to the accident as the Assignor had no preexisting injuries. As such, the medical necessity for the facility fee for the perioperative block injection has been established.

Fee Schedule

Respondent argued that the fee charged are inappropriate for the services provided. Respondent submits a fee audit from Signet Claim Solutions signed by a non-certified professional coder Joanne Silverman-Ungar. There is no fee explanation, medical explanation or peer review report which establishes the reasons for the deduction. It is merely a conclusory one page audit declining certain codes with no true explanation.

Respondent has failed to provide valid justification for these downcodings or denials. More importantly, Respondent failed to provide an expert opinion in support thereof (e.g. a peer review or medical audit). Respondent did not provide anything to suffice as an expert opinion or documentary proof of justification for these downcodings and/or denials, specifically how this is related to a multiple modality reduction. These are just conclusory positions not supported by any evidence.

Respondent has the burden of coming forward with "competent evidentiary proof" supporting its fee schedule defenses (see *Continental Med., P.C. v. Travelers Indem. Co.*, 11 Misc.3d 145a (2006)).

An insurer fails to establish the existence of an issue of fact with respect to a defense that fees charged were excessive and not in accordance with the Workers' Compensation fee schedule in the absence of proof establishing the defense (see *St. Vincent Medical Care, P.C. v. Country Wide Ins. Co.*, 26 Misc.3d 146(A), 907 N.Y.S.2d 441 (Table), 2010 N.Y. Slip Op.50488(U), 2010 WL 1063914 (App. Term 2d, 11th & 13th Dists. Mar. 19, 2010)).

An insurer fails to raise a triable issue of fact with respect to a defense that the fees charged were not in conformity with the Workers' Compensation fee schedule when it does not specify the actual reimbursement rates which formed the basis for its determination that the claimant billed in excess of the maximum amount permitted (see *Vincent Medical Services, P.C. v. GEICO Ins. Co.*, 29 Misc.3d 141(A), 907 N.Y.S.2d 441 (Table), 2010 N.Y. Slip Op. 52153(U), 2010 WL 5116892 (App. Term 2d, 11th & 13th Dists. Dec. 8, 2010)).

Accordingly, after a careful review of the records and consideration of the parties' oral arguments, I find that Respondent offered no objective evidence in support of its reductions and therefore failed to sustain its fee schedule denial. I therefore find for the Applicant. Reimbursement as requested is due and owing herein in the full claim amount for \$1,400.51.

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
	Advanced Medical Concepts	08/12/15 - 09/08/15	\$1,400.51	Awarded: \$1,400.51
Total			\$1,400.51	Awarded: \$1,400.51

- B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 04/12/2016, which is a relevant date only to the extent set forth below.)

Applicant is awarded interest pursuant to the No-Fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30-day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. "If an applicant does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or payment of benefits calculated pursuant to Department of Financial Services regulations, interest shall not accumulate on the

disputed claim or element of claim until such action is taken." 11 NYCRR §65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009).

C. Attorney's Fees

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

Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or the court, subject to a maximum fee of \$850." Id. The minimum attorney fee that shall be awarded is \$60. 11 NYCRR §65-4.5(c). 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(i). For claims that fall under the Sixth Amendment to Subpart 65-4 of Title 11 NYCRR the following shall apply " If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved disputes, subject to a maximum fee of \$1,360." (Emphasis added)

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

11/03/2017
(Dated)

Bryan Hiller

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:
a78e4806fb82170e3385f5d0029d2dce

Electronically Signed

Your name: Bryan Hiller
Signed on: 11/03/2017