

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Dassa Orthopedic Medical Services P.C.
(Applicant)

- and -

American Transit Insurance Company
(Respondent)

AAA Case No. 17-16-1051-8256

Applicant's File No. TM-16-3341

Insurer's Claim File No. 660687-05

NAIC No. 16616

ARBITRATION AWARD

I, Paul Weidenbaum, 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

1. Hearing(s) held on 01/11/2018
Declared closed by the arbitrator on 01/11/2018

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

David Bendik from Short & Billy PC participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 10,410.62**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount claimed in No-Fault benefits was amended during the arbitration hearing from \$10,410.62 to \$7,611.75 in order to conform to New Jersey Fee Schedule, and the amendment was permitted by this arbitrator.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

Whether the Respondent's assertion of outstanding verification, and Respondent's defense based on the 120 day rule can be sustained?

4. Findings, Conclusions, and Basis Therefor

This arbitration arises out of medical treatment received by the Assignor following a motor vehicle accident in which the 38 year old male Assignor was involved on 6/4/15.

The amount originally claimed in No-Fault benefits as reimbursement for arthroscopic surgery to the injured person's right knee is \$10,410.62. However, during the arbitration hearing, Applicant's counsel amended the amount claimed in No-Fault benefits to \$7,611.75 in order to conform to the New Jersey Fee Schedule pursuant to Ground Rule 5.

At the outset, it should be noted that the claim was not timely denied. A review of the submission discloses that no denial was issued by the carrier. Rather, the carrier delayed for verification. In the absence of a denial of claim form, Respondent is precluded from raising most defenses. Here, the Respondent has raised a defense which is not precluded in the absence of a denial. Applicant has submitted a corresponding proof of mailing establishing its bill was, in fact, submitted to the Respondent on 10/26/15. Accordingly, the Applicant has established a *prima facie* case of entitlement to No-Fault benefits.

120 Day Rule

Pursuant to 11 NYCRR Section 65-3.5(o), an applicant from whom verification is requested shall, within 120 calendar days from the date of the initial request for verification, submit all such verification under the applicant's control or possession, or written proof providing reasonable justification for the failure to comply. The insurer shall advise the applicant in the verification request that the insurer may deny the claim if the applicant does not provide within 120 calendar days from the date of the initial request either all such verification under the applicant's control or possession or written proof providing reasonable justification for applicant's failure to comply. This subdivision shall not apply to a prescribed form [NF Form] as set forth in Appendix 13 of this Title, medical examination request, or examination under oath request."

Prior to the amendment the regulation did not "impose a deadline for responding to a verification request nor permit an insurer to deny a claim if it never receives the requested verification, allowing some claims to remain open indefinitely." See, *Regulatory Impact Statement for the Fourth Amendment to 11 NYCRR 65-3*. The intent of the amendment was to "reduce the number of claims that remain open indefinitely by requiring an applicant for benefits to either submit any requested verification within the applicant's control or possession, or provide reasonable justification for failing to do so within 120 calendar days from the date of the initial verification request."

The legislative intent of the no-fault regulation "demonstrates an interest in prompt resolution of reimbursement claims, a desire to avoid litigation, and statutory consequences on an insurer to incentivize it to seek verification of a claim, deny it or pay. No-Fault reform was enacted to provide prompt uncontested, first-party insurance benefits. That is part of the price paid to eliminate common-law contested lawsuits. The

tradeoff of the no-fault reform still allows carriers to contest ill-founded, illegitimate and fraudulent claims, but within a strict, short-leashed contestable period and process designed to avoid prejudice and red-taped dilatory practices." See, *Viviane Etienne Medical Care, P.C. v. Country Wide Ins. Co.*, 25 N.Y. 3d 498 [2015], citing to, *Presbyterian Hospital in the City of N.Y. v. Maryland Cas. Co.*, 90 N.Y. 2d 274 [1997].

Indeed, prior to the amendment the "prompt resolution" of claims was often frustrated by the open-ended nature of the verification procedures, which resulted in applicant's failing to respond to verification requests, leaving claims unresolved for months and even years. The verification procedures were slowed further by dilatory correspondence and gamesmanship from both sides resulting in ultra-technical arguments, which were never intended by the drafters of the regulation. Ultimately, the intent of the regulation has always been for both sides to communicate with one another in order to verify and resolve the claim.

Respondent has a duty to communicate with Applicant and vice versa. The parties' obligations are grounded in good faith and common sense. Any questions concerning communication should be addressed by further communication, not inaction. *Dilon Medical Supply Corp. v. Travelers Ins. Co.*, 7 Misc.3d 927, 796 N.Y.S. 2d 872 [Civ. Ct. Kings Co. 2005]. The response to a verification request that is "arguably responsive" places the burden to take further action upon the carrier. *All Health Medical Care, P.C. v. GEICO*, 2 Misc. 3d 907 [N.Y. City Civ. Co. 2004]. Moreover, as long as applicant's documentation is arguably responsive to an insurer's verification request, the insurer must act affirmatively once it is in receipt of a response to its verification request. *Media Neurology, P.C. v. countrywide Ins. Co.*, 21 Misc. 3d 1101 [N.Y. City Civ. Ct. 2005].

The intent of the amendment was not to lead to further technical arguments by both sides. The purpose was to speed up and enhance the verification process by implementing a time frame for applicants to respond. The goal is to motivate applicants to respond promptly and to provide insurers with the ability to act if an applicant chooses to sit on their hands.

In the event of applicant's failure to respond, the intent is to *act* as it *may-not shall*-deny the claim if it fails to receive verification within 120 calendar days or any time thereafter. The fact that the regulation does not impose a time frame or requirement to deny the claim further supports the idea that the purpose of the amendment is the promotion of expeditious verification of the claim.

An insurer's failure to deny the claim following the 120 days does not relieve the applicant of its obligation to reply, and until the claim is denied *prior* to receipt of verification, the claim can either be denied or remain open as the carrier may choose. However, if the carrier elects not to deny the claim, an applicant should, at any time beyond the 120 days, submit its response to the verification request. There is nothing in the regulation which prohibits a "late" response from an applicant prior to the affirmative denial of the claim.

In the event an applicant submits a response to a verification request either within the 120 day period, or following the 120 day period wherein no denial was issued-an

insurer is under an obligation to act. If the verification is complete, the claim should be processed accordingly-that is to say, paid or denied. If the verification is incomplete, respondent must take action identifying the deficiency and advising applicant of same. Applicant is then required to respond.

Based upon the foregoing, a denial predicated on the 120 day rule will not be sustained when: (1) an applicant fully responds to a verification request within 120 days; (2) an applicant responds to a verification request but such response is deemed to be incomplete by an insurer within 120 days; (3) an applicant fully responds to a verification request more than 120 calendar days from the date of the initial request, but prior to the issuance of a denial of claim form [NF-10]; and (4) an applicant responds to a verification request beyond 120 days but such response is deemed incomplete by an insurer. Once an applicant has made an attempt to comply with the verification request, the carrier's denial option is foreclosed, and it is incumbent upon both sides to act in a reasonable and responsive manner to complete the verification of the claim.

Ultimately, whether the correspondence was "arguably responsive" or constituted either "action" or "inaction" will be a question of fact for determination by the trier of fact.

In the instant matter, the Respondent initially sent a verification request letter dated 11/12/15 to New Horizon Surgical Center-not to the Applicant herein. In the verification request letter to New Horizon Surgical Center, the Respondent requested the following:

- Please submit a copy of the MRI film of the right knee for which this procedure was conducted, color photos of the surgical procedure, and a letter of medical necessity to show causal relation to motor vehicle accident of record;
- Please submit medical records, reports, progress notes, office notes, treatment records/notes, diagnostic test reports and medical referrals for treatment provided to the injured person prior to, concurrent with, and subsequent to the treatment provided by your facility including, but not limited to, physical therapy, massage therapy, acupuncture, chiropractic, diagnostic testing, and a letter of medical necessity to show causal relation to motor vehicle accident of record;
- BILL IS DELAYED PENDING VERIFICATION AS TO WHY THIS FACILITY WAS USED. CLAIMANT LIVES IN BRONX, NEW YORK AND THIS FACILITY IS IN NEW JERSEY. WHO DECIDED THIS PROCEDURE WAS MEDICALLY NECESSARY AND PLEASE PROVIDE DOCUMENTATION OF THE NECESSITY.

The Respondent next sent an additional letter to New Horizon on 8/14/16, in which Respondent demanded production of the following:

- Please provide a list of all owners of New Horizon and each owner's % of ownership;
- Please provide a copy of all written disclosures made by New Horizon to the patient of its financial relationship with the doctors who made the referral and/or performed the surgery;

- Please provide copies or [photos of all posted ownership[and dual financial interest paperwork;
- Please provide all accreditation packages for all the medical doctors, chiropractors and physician's assistants who performed the underlying procedures/surgeries for the claims at issue;
- Please provide a copy of the spreadsheet that lists all providers credentialed at New Horizon Surgical, past and current;
- Please provide the procedure booking sheet for the bills at issue;
- Please provide a copy of New Horizon Surgical's pre-admission test guidelines;
- If Code 27194 was billed, please advise if patient had a pelvic ring fracture, or a diagnosis for one;
- Please provide all contracts between New Horizon Surgical and its billing company, transportation companies, and anesthesia providers;
- Please provide a copy of New Horizon Surgical's lease for 680 Broadway, Suite 201 and 205, Paterson, New Jersey

Respondent sent a follow-up letter to New Horizon Surgical Center dated 9/8/16.

The Respondent's only correspondence with the Applicant herein consisted of an initial letter dated 8/18/16 in which no documentation or other verification was requested directly from the Applicant itself. Rather, the 8/18/16 letter from the Respondent advised the Applicant that verification requests had been made upon another provider and Respondent was awaiting the response from that other provider to a number of verification requests. A follow-up letter identical to the 8/18/16 letter was sent by Respondent to the Applicant on 9/22/16.

Applicant herein asserts it did not violate the 120 day rule because it never received the verification requests. Based upon the materials submitted, this is true-the verification requests were admittedly sent to a different provider. The Applicant was clearly in no position to furnish the Respondent with the verification requested of New Horizon Surgical Center as Applicant does not have custody, control and possession of the documents and records generated and maintained by New Horizon.

However, viewing the evidence in the light most favorable to the Respondent, I note that there was extensive communication between counsel for Respondent and Dassa Orthopedic Medical Services, P.C., [hereinafter referred to as DOMS]as follows:

On 1/25/16, Respondent's counsel sent a letter to DOMS, stating:

"In lieu of Dassa Orthopedic Medical Services' personal appearance to testify at the Examination Under Oath requested by American Transit Insurance Company on the claims listed below, Dassa Orthopedic Medical Services agrees to provide to American Transit Insurance Company, a verified response to certain questions. The verification questions will be sent via mail and e-mail to the addresses listed below. Under the regulations, the Insurer may deny the claims for the provider's failure to cooperate with the verification process. If the provider fails to submit its response within 120 calendar days from the date of the initial request for verification. The response should address all verification requested that is under your control or possession or include written proof providing reasonable justification for your failure to comply.

The parties agree that American Transit Insurance Company's requests will be considered timely if mailed and e-mailed on or before February 8, 2016. The time to respond will run from the date on which the request is mailed and e-mailed."

Thereafter, on 2/1/16, Respondent's counsel sent the requests for verification to DOMS. There were a total of eleven (11) requests set forth in this correspondence, including the one which is most critical to this arbitration proceeding as counsel for Respondent forcefully argued during the arbitration hearing that it is the one which the Applicant has not fully complied with. Specifically, Respondent's first two questions were as follows:

- 1. Is Dr. Dassa an officer, owner and/or employee of the surgery center where the services were performed?***
- 2. If so, has this been disclosed to the patient and please provide a copy of said disclosure.***

By letter dated 3/31/16, DOMS provided its response to the questions put to it by Respondent. The contents of DOMS' 3/31/16 letter are set forth below:

"As agreed, please see below the Response to Verification Requests by American Transit Insurance Company on 2/1/16.

- 1. Yes, Dr. Dassa owns two shares in the New Horizon Surgery Center where the services were performed.***
- 2. Yes, it was disclosed to the patient. A reference to the ownership is also posted on the Surgery Center Web-Site.***
- 3. Dr. Dassa has no participation on any level in any Office Based Surgery Practice.***
- 4. N/A. (The information sought by the question was: If so, please state the name and location of the Office Based Surgery Practice).***
- 5. Dr. Dassa is part owner of Empire State Ambulatory Surgery Center and New Horizons Surgery Center.***

6. Empire State Ambulatory Surgery Center

3170 Webster Avenue

Bronx, N.Y. 10467

New Horizons Surgery Center

680 Broadway

Paterson, N.J. 07514

- 7. Dr. Dassa is a Licensed Physician in NJ. He maintains an office at 1010 Clifton Ave., Clifton, New Jersey. He examines patients in both NY and NJ on a weekly basis. He schedules patients for surgery both in NY and NJ on a future availability schedule. Scheduling decisions are based on Block Time availability and the need to accommodate patients. Additionally, it is based on the availability of equipment for certain necessary surgical procedures. Dr. Dassa performs surgical procedures in both New York and New Jersey. The surgery for the case in question was done in New Jersey because that was the location that was able to accommodate the doctors need for block time to accommodate his schedule and the needs of his patients for the time frame. Additionally the New York Surgery Center, which is relatively new, did not have the experience, equipment, nor the proper support staff to allow Dr. Dassa to perform this surgical procedure properly and insure the safety of the patient and high prospect for a successful outcome.**
- 8. The same services could not have been done in NY. The surgery was done in New Jersey because that was the location that was able to accommodate the doctors need for block time to accommodate his schedule and the needs of his patients for the time frame. Additionally the New York Surgery Center, which was relatively new, did not have the experience, equipment, nor the support staff to allow Dr. Dassa to perform this surgical procedure properly and insure the safety of the patient and high prospect for a successful outcome.**
- 9. Dr. Dassa does not perform any surgical procedures in any office based surgical facilities. His cases are usually too complicated from a medical point of view and, his patients generally have significant co-morbidities due to having several co-existing medical problems. Even though the doctor obtains the necessary medical clearances prior to surgeries, there always exists the potential for operative complications. Should such complications arise, office based surgery practices lack the expertise or support staff to deal with the level of complicated surgeries that Dr. Dassa performs.**
- 10. Dr. Dassa did not provide transportation for the patient to the surgery center nor does he know how the patient arrived there.**
- 11. See attached (Certificate of Authorization to do business in New Jersey)''**

On 4/22/16, Respondent's counsel sent the following letter to DOMS:

"Thank you for your response to verification dated March 31, 2016 and received on April 11, 2016.

Please be advised Dassa Orthopedic Medical Services has not submitted a complete response and the bills referenced herein are being further delayed pending the receipt and completion of the following:

Please provide a copy of the disclosure which was given to the patient at issue informing them that Dr. Dassa is an officer, owner and/or employee of the surgery center where the services were performed."

Thereafter, sometime in May 2016, DOMS sent to Respondent's counsel a generic disclosure form which contains the following language:

"NOTICE TO PATIENTS

NEW YORK LAW Regulations found in 10 NYCRR Sec. 34.1 require that a disclosure form be provided to patients by practitioners for referrals not prohibited in the statute.

Because of concerns that there may be a conflict of interest when a physician refers a patient to a health-care facility in which the physician has a financial interest, New York State requires that I disclose this financial interest if it exists. It is also required that I inform you about alternative places where you may go to obtain these services. This disclosure is intended to help you make a fully informed decision about your health care.

I, Gabriel L. Dassa, D.O., have financial relationship with the following providers:

NEW HORIZONS SURGICAL CENTER

680 Broadway

Paterson, NJ 07514

You may seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory or on the Internet under the appropriate heading. You may also ask my staff about alternative providers. We will provide you with names and addresses of places best suited to your individual needs.

Further information can be obtained at www.newhorizonsasc.com in the About tab under Ownership Disclosure."

On 6/10/16, Respondent's counsel sent the below correspondence to DOMS:

"Thank you for your response to verification received on June 1, 2016.

Please be advised Dassa Orthopedic Medical Services has not submitted a complete response and the bills referenced herein are being further delayed pending the receipt and completion of the following:

The practitioner has provided a copy of a generic disclosure form and has cited 10 NYCRR section 34 which requires use of a specific form See 10 NYCRR 34-1.6. Additionally 10 NYCRR section 34-1.4 requires that the practitioner maintain disclosure provided to each patient.

Please specify if the form provided and received on June 1, 2016 was given to each of the below patients or if it is a general form being used by the provider.

Please provide the specific disclosure for the patients named below."

On July 15, 2016, Respondent's counsel wrote to DOMS again, stating:

"Thank you for your response to verification received on June 1, 2016.

Please be advised that Dassa Orthopedic Medical Services has not submitted a complete response and the bills referenced herein are being further delayed pending the receipt and completion of the following:

Please provide specific disclosure for the patients named below."

In response, DOMS forwarded a statement signed by Dr. Dassa in which the doctor avers the following:

To Whom It May Concern:

RE: Response to Verification request-File#52462 and File #54699

Dassa Orthopedic Medical Services a/s/o [the injured person in this case] v. American Transit Insurance Company claim #660687-05

Dear Sir or Madam:

Please note that the generic disclosure was given to each of the patients who was scheduled or underwent surgical procedure at New Horizons Surgery Center. Each patient became aware of Dr. Dassa's relationship with the New Horizon Surgery Center and then, confirmed their decision to perform surgery at the same facility."

Subsequent thereto, an exchange of e-mail communications occurred between the offices of the Respondent's counsel and the Applicant's counsel with respect to the disclosure of Dr. Dassa's financial interest in the New Horizons Surgery Center. The sequence of these e-mail communications is as follows:

On 10/12/16 at 11:32 a.m., Anila Witonski of the office of Applicant's counsel wrote to Mr. Short of the Respondent's counsel, the following:

"Just a reminder about the two above-referenced cases. Did you get authority to settle? If not, we will have to file for arbitration. Please let us know when you get a chance."

At 1:26 p. on the same day, 10/12/16, John Belesi of the office of applicant's counsel wrote this to Mr. Short:

"The disclosure letter was shown to each patient."

Immediately thereafter, at 1:27 p.m. on 10/12/16, Mr. Short wrote back to further inquire:

"do any have their names or a date

I thought from EUO he did not say they were doing it at that time

was there a time when he started

and are they ever signed by patient or with patient name added"

On 10/25/16, Dr. Dassa, in response to these inquiries, sent the following signed statement:

"To Whom It May Concern:

This letter is written in request for information regarding my disclosure to patients of my ownership interest in New Horizon Surgical Center. I have been performing surgeries in New Horizon Surgical Center since 2014.

My B share ownership interest was approved by the New Jersey DOH in January 2015. I have been disclosing to patients my ownership interest in New Horizon Surgical Center since the time of my approval of ownership interest.

If you have any questions, please feel free to contact me."

The final e-mail communication in the series is from 11/17/16 at 10:32 a.m, and was an internal communication written by Skip Short to John Belesi, both of the Respondent's counsel's office, and states:

"We have contacted ATIC (American Transit Insurance Company)

Only one dassa bill remains open

See below. The other was denied on exhaustion.

656284-01-Bill denied based on policy exhaustion.

660687-05-Bill denied as instructed.

Please be advised the bill submitted for services rendered on 9/30/15 in the amount of \$10,410.62 is in delay status pending the verification response of New Horizon Surgical in connection with the services rendered. We will release the claim upon receipt of New Horizon's response."

The record reflects that about an hour later, at 11:31 a.m. on 11/17/16, Mr. Belesi of the Respondent's counsel's office forwarded this e-mail to Anila Witonski of Applicant's counsel's office.

Counsel for the Respondent argued during the hearing that the disclosure made by Dr. Dassa to the Assignor in this case was insufficient, and that the applicable law requires that the patient sign the disclosure indicating that he or she has read it. The statute to which Respondent's counsel referred is New York Public Health Law 238-d.

New York Public Health Law 238-d bars a practitioner from making a referral to another health care provider for the furnishing of any health or health related items or services where the referring provider has a financial relationship with the billing provider without disclosing such financial relationship to the patient. Counsel for the Respondent asserts that this applies to the services billed by the Applicant, and I agree. A "financial relationship" is defined in Section 238(3) to include a "compensation arrangement". A "compensation arrangement" is defined in Section 238-a(5)(a) as "any arrangement involving any remuneration between a practitioner, or immediate family member, and a health care provider. The term remuneration includes any remuneration, directly or indirectly, overtly or covertly, in cash or in kind."

For services other than radiology services, under New York's Public Health Law, self-referrals are forbidden in the absence of full disclosure of such self-referral to the patient. Public Health Law Section 238-d states:

"Practitioner disclosure requirements: 1. With respect to referrals not prohibited pursuant to this title, and except as provided in subdivision three of this section, a practitioner may not make a referral to a health care provider for the furnishing of any health or health related items or services where such practitioner or immediate family member of such practitioner has any of the following financial relationships without disclosing to the patient such financial relationship:

- (a) An ownership or investment interest, as defined in subdivision three of section two hundred thirty-eight of this title, with such health care provider; or*
- (b) A compensation arrangement, as defined in subdivision five of section two hundred and thirty-eight-a of this title, with such health care provider which is in excess of fair*

market value or which provides for compensation that varies directly or indirectly based on the volume or value of any referrals of business between the parties.

The disclosure shall provide notice of any such financial relationship and shall also inform the patient of his or her right to utilize a specifically identified health care provider if any such alternative is reasonably available, and shall be provided in a brief and reasonable form and manner specified in regulations proposed by the commissioner in consultation with consumer and physician organizations adopted by the public health council, subject to approval by the commissioner."

Respondent's counsel notes that The Health Department has prescribed a mandatory form which must be used and sets forth the information which must be disclosed. The Department of Health regulations require that this disclosure be in writing and that it be on a specific form that must be used pursuant to the Regulations. 10 NYCRR Section 34-1.5 provides in relevant part:

"Disclosure: other health or health related items or services (a) with respect to referrals for health or health related items or services other than clinical laboratory services, pharmacy services, radiation therapy services, or X-ray or imaging services, and except as provided in subdivision (c) of this section, a practitioner may not make a referral to a health care provider for the furnishing of health or health related items or services where such practitioner or immediate family member of such practitioner has any of the following financial relationships without disclosing to the patient such financial relationship: (b) the disclosure shall provide notice of any such financial relationship and shall also inform the patient of his or her right to utilize a specifically identified alternative health care provider if any such provider is reasonably available, and shall be in the form specified in section 34-1.6 of this Subpart. Such form shall also be posted prominently in the practitioner's office."

10 NYCRR Section 34-1.6 sets forth the form that must be used as follows:

Section 34-1.6 Disclosure form

NOTICE TO PATIENTS

Because of concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has a financial interest, New York State passed a law. The law prohibits me, with certain exceptions, from referring you for clinical laboratory services, pharmacy services, radiation therapy, or X-ray or imaging services to a facility in which I or any of my immediate family members have a financial interest. If certain of the exceptions in the law apply, or if I am referring you for other than clinical laboratory, pharmacy, radiation therapy services, or X-ray or imaging services, I can make the referral under one condition. The condition is that I disclose this financial interest and tell you about alternative providers where you may go to obtain these services. This disclosure is intended to help you make a fully informed decision about your health care.

I or my immediate family members have a financial relationship with the following providers:

For more information about alternative providers, please ask me or my staff. We will provide you with names and addresses of providers best suited to your individual needs that are nearest to your home or place of work.

Of significance, I note that the prescribed form of the notice to the patient of the referring physician's financial interest in the health care provider to which he is referring the patient does not contain any line for the patient's signature or acknowledgment.

In the Respondent's brief, which I have read in its entirety, counsel also cites to a similar New Jersey statute:

Title 45. Professions and Occupations

45:9-22.5 Reference to health care service by practitioner with significant beneficial interest; disclosure to patient; exceptions

- a. A practitioner shall not refer a patient or direct an employee of the practitioner to refer a patient to a health care service in which the practitioner, or the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family has a significant beneficial interest...*
- b. If a practitioner is permitted to refer a patient to a health care service pursuant to this section, the practitioner shall provide the patient with a written disclosure form, prepared pursuant to section 3 of P.L. 1989, c. 19 (C.45:9-22.6), and post a copy of this disclosure form in a conspicuous public place in the practitioner's office.*
- c. The restrictions on the referral of patients established in this section shall not apply to:*
 - (1) Medical treatment or a procedure that is provided at the practitioner's medical office and for which a bill is issued directly in the name of the practitioner or the practitioner's medical office;*
 - (2) Renal dialysis; and*
 - (3) Ambulatory surgery or procedures requiring anesthesia performed at a surgical practice registered with the Department of Health pursuant to subsection g. of section 12 of P.L 1971, c. 136 (C.26:2H-12) or at an ambulatory care facility licensed by the Department of Health to perform surgical and related services, if the following conditions are met:*
 - (a) the practitioner who provided the referral personally performs the procedure;*

- (b) *the practitioner's remuneration as an owner of or investor in the practice or facility is directly proportional to the practitioner's ownership interest and not to the volume of patients the practitioner refers to the practice or facility;*
- (c) *all clinically-related decisions at a facility owned in part by non-practitioners are made by practitioners and are in the best interests of the patient; and*
- (d) *disclosure of the referring practitioner's significant beneficial interest in the practice or facility is made to the patient in writing, at or prior to the time that the referral is made, consistent with the provisions of section 3 of P.L. 1989, c. 19 (C. 45:9-22.6).*

Respondent's counsel argues that a violation of the statute is a complete defense to a claim for payment of the claim and is a non-precludable defense under the holding in *Fair Price Medical Supply v. Elrac*, 12 Misc. 3d 119 (App. Term 2nd & 11th Jud. Dists. 2006); *Ozone Park Medical Diagnostic Assoc. v. Allstate Ins. Co.*, 180 Misc. 2d 105 (App. Term 2nd Dept. 1999); and *Stand Up MRI v. General Assurance*, 10 Misc. 3d 551 (Suffolk dist. Ct. 2005).

Once a facial violation of the self-referral statute has been established, argues Respondent's counsel, the burden shifts to the Applicant to demonstrate that it did not violate the Public Health Law.

After an exhaustive and searching review of all the evidence presented, I find that the financial relationship which exists between Dr. Dassa and New Horizon Surgery Center was, in fact, properly disclosed in compliance with the requirements set forth in the statute relied upon by counsel for the Respondent.

I further find that contrary to the argument advanced by Respondent's counsel during the arbitration hearing, to the effect that the statute imposes a requirement that the disclosure form be signed by the patient to indicate that he or she has read the disclosure and understands his or her rights to utilize the services of alternative health care provider, that the statutory language contains no such requirement.

Respondent's counsel cited an earlier arbitration award in support of its position. Specifically, in a decision rendered on 3/16/16, Arbitrator Timothy McNamara [AAA Case Number 17-15-1004-6414], in finding in favor of the Respondent therein, wrote:

"Counsel for the respondent sought a copy of the signed recognition agreement advising the patient [EIP] of the common ownership of facilities and medical practice, Avanguard and Metropolitan. Respondent advised that there were, in various places in the office on the wall advising of the common ownership between facilities and doctor. They further advised there were no written disclosures signed by the patient.

The issue now being is written disclosure signed by the patient required under the regulation, or in fact is the mere posting of signs enough to satisfy the regulations.

After reviewing all of the documents, and having a lengthy discourse between counsel and arbitrator I find that the applicant did not meet the requirement of notice. Few if any patients read the signs on the wall. A full and complete disclosure with a meaningful response by the patient in the form of a signed document is needed."

Another prior arbitration award cited by the Respondent in support of its position is clearly distinguishable from the facts and circumstances of the instant matter. Specifically, in his decision in AAA Case number 17-13-9040-4201, which involved interpretation of New York Public Health Law 238-a and 238-d, heard by Arbitrator Stephen Czuchman on 1/22/16, the arbitrator wrote:

"It is uncontroverted that applicant's owner, Mark Gladstein, M.D. who signed the bills for the disputed evaluations is listed as the referring provider on the bills, also at least in part owns Avanguard Medical Group, PLLC, the OBSP where the disputed injections were performed. Further, Dr. Gladstein admitted to a financial relationship and lease agreement between Avanguard and applicant and that he made payments to referring providers in an affidavit and a 3/25/11 examination under oath (EUO)... There is no credible evidence here indicating that the patient was informed of the financial relationship between applicant and Avanguard; rather, all we have are Dr. Gladstein's hearsay statements in his affidavit that he verbally informed his patients of applicant's financial relationship with Avanguard. PHL Section 238-d mandates any medical provider engaging in self-referrals provide disclosure to a patient that gives "notice of any such financial relationship and shall also inform the patient of his or her right to utilize a specifically identified alternative health care provider if any such alternative is reasonably available, and shall be provided in a brief and reasonable form and manner specified in regulations proposed by the commissioner in consultation with consumer and physician organizations and adopted by the public health council, subject to approval by the commissioner...10 NYCRR Section 34-1.5 mandates that such disclosure be made in writing...Applicant has made no showing that the financial arrangement between applicant and Avanguard was disclosed in writing to the patient according to 10 NYCRR Section 34-1.5 or that the financial relationship fell within the safe harbor provision of the PHL. Accordingly, based on a fair preponderance of the credible evidence, the claim is denied in its entirety."

ANALYSIS OF THE ARBITRATION AWARDS CITED BY RESPONDENT/RELEVANCE TO THE INSTANT CASE

While I agree that merely posting a sign on the wall of the practitioner's office containing notice to patients of the financial relationship encompassed by the regulation is insufficient to satisfy the notice requirement, I must respectfully disagree with my learned colleague, Arbitrator McNamara, as any interpretation of the statutory and/or regulatory language which determines that a "meaningful response by the patient in the form of a signed document is required" can find no support in the statutory language.

Simply put, nowhere in the section of the New York Public Health Law, or in the section of the applicable New Jersey statute, or in 10 NYCRR Section 34, relied upon by Respondent's counsel, is any such requirement to be found. This arbitrator declines to "read in" a legislative intent on the part of the legislators who drafted the relevant statutes for which no evidence exists in the language those legislators chose to employ.

With respect to the decision of Arbitrator Czuchman, the findings of fact in that case are clearly distinguishable from those in the instant case. In the case involving Dr. Gladstein and Avanguard, the credible evidence showed only that the referring practitioner, Dr. Gladstein, "verbally informed his patients of applicant's financial relationship with Avanguard." By contrast, in the instant matter, Dr. Dassa went well beyond a verbal advisory to his patients of his financial interest in New Horizon Surgery Center.

The credible evidence in this case establishes that Dr. Dassa provided his patients, including the Assignor herein, with notice in the statutorily required format both of his financial interest in New Horizon Surgery Center and of the right of the patient to choose to use an alternative to New Horizon Surgery Center in which the referring physician, Dr. Dassa, did not have a financial interest. In sum, in the case involving Dr. Gladstein and Avanguard, decided by Arbitrator Czuchman, the evidence showed a failure by the referring physician to comply with the notice requirements imposed by the applicable section of the Public Health Law. In the case before me involving Dr. Dassa and New Horizon Surgery Center, the credible evidence shows that there has been full compliance with the spirit and intent, as well as the letter, of the applicable law.

Therefore, I find that on the totality of the evidence presented herein, the Respondent's delay for verification was inappropriate since it delayed denying or paying the claim of the Applicant based upon the Applicant's alleged failure to comply with a requirement which no applicable statute or regulation imposes on a practitioner who refers a patient to a health care facility in which that practitioner has a financial interest. There has, in fact, been full compliance by Dr. Dassa with the relevant notice requirements as it relates to his financial stake in New Horizon Surgery Center.

I find that the statutory scheme with respect to disclosure of such financial interest on the part of the referring practitioner requires him or her to disclose that financial interest to the patient, and to inform the patient that he or she has the right to utilize the services of an alternative health care facility in which the referring practitioner does not have any financial interest. This Dr. Dassa most certainly appears to have done.

The evidence presented herein supports a finding that Dr. Dassa and/or Dassa Orthopedic Medical Services fully complied with the disclosure requirement imposed within the four corners of the relevant statute(s) enacted by the legislatures of the State of New York and the State of New Jersey.

For the foregoing reasons, I find the Applicant did not violate the 120 day rule. Accordingly, I find for the Applicant and reimbursement of the amended amount of \$7,611.75 herein is due and owing.

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	Amount Amended	Status
	Dassa Orthopedic Medical Services P.C.	09/30/15 - 09/30/15	\$10,410.62	\$7,675.11	Awarded: \$7,675.11
Total			\$10,410.62		Awarded: \$7,675.11

- B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 01/06/2017, which is a relevant date only to the extent set forth below.)

Interest runs from the filing date for this case until payment has been 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 Section 65-4.6(c) and (e). However, if the benefits and interest awarded thereon are less than or equal to the Respondent's written offer during the conciliation process, the attorney's fee shall be based upon the provisions of 11 NYCRR Section 65-4.6(b). for cases filed after February 4, 2015 there is no minimum fee and a maximum fee of \$1,360.00.

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

02/10/2018
(Dated)

Paul Weidenbaum

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:
a56aa1e58fd0c92e2e152eaf2a7575cd

Electronically Signed

Your name: Paul Weidenbaum
Signed on: 02/10/2018