

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Alan J Dayan M.D.  
(Applicant)

- and -

Geico Insurance Company  
(Respondent)

AAA Case No.	17-17-1076-4744
Applicant's File No.	None
Insurer's Claim File No.	0491155010101069
NAIC No.	35882

**ARBITRATION AWARD**

I, Giovanna Tuttolomondo, 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 11/08/2018  
Declared closed by the arbitrator on 11/08/2018

Karen Wagner, Esq. from Dash Law Firm, P.C. participated in person for the Applicant

Robert LoFurno, Claims Representative from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 5,121.81**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant amended the amount in dispute to \$ 2,509.13 to reflect an amount that it believes to be consistent with the applicable Fee Schedule.

Stipulations WERE made by the parties regarding the issues to be determined.

The parties agreed to the submission of the claim and issuance of a timely denial.

3. Summary of Issues in Dispute

The Assignor, PB, now a 35-year-old female, was the driver of a motor vehicle involved in an accident on June 24, 2016. Thereafter, the Assignor sought medical attention for the injuries sustained in the accident. At issue in this case is a claim totaling \$ 2,509.13, representing shoulder surgery performed on the Assignor on October 16, 2016. Respondent denied Applicant's claim for reimbursement based upon the Peer Review of Jules D. Hip-Flores, M.D., dated November 11, 2016. The issue presented is that of medical necessity. In addition, should necessity be established, Respondent also raises a Fee Schedule defense.

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

The decision in this case is based upon the oral arguments of the parties' representatives at the hearing and upon my review of the submissions of the parties as contained in the Electronic Case Folder maintained by the American Arbitration Association. I have reviewed the documents in MODRIA as of the date of closing of this file and incorporate, and rely upon, said documents in making my decision.

#### **MEDICAL NECESSITY**

Once Applicant has established a prima facie case, and in order to rebut the presumption of medical necessity, the burden then shifts to insurer-Respondent to present sufficient evidence to establish a lack of medical necessity for the services rendered. The insurer bears the burden of production. Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 13 Misc. 3d 136(A), 831 N.Y.S.2d 351(Table)(App. Term 1<sup>st</sup> Dept. 2006).

In order to establish a medical necessity defense, an insurer must present a sworn-to peer review or an independent medical review report which sets forth a factual basis and medical rationale for the doctor or professional's opinion that the services were not medically necessary. Elmont Open MRI & Diagnostic Radiology, P.C. v. Tri-State Consumer Ins. Co., 34 Misc. 3d 141(A), 950 N.Y.S. 2d 491 (Table)(App. Term 9<sup>th</sup> and 10<sup>th</sup> Jud. Dists. 2012).

A Peer Review cannot be conclusory. There must be reference to the generally accepted medical/professional practice. "Generally accepted practice is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." Citywide Social Work and Psychological Servs. v. Travelers Indem. Co., 3 Misc. 3d 608, 777 N.Y.S. 2d 241 (N.Y. City Civ. Ct. Kings Co. 2004).

Where the insurer presents sufficient evidence to establish a defense based on a lack of medical necessity, the burden then shifts to the provider who must then present its own evidence of medical necessity. A Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co., 16 Misc. 3d 131(A), 841 N.Y.S.2d 824 (Table)(App. Term, 2d and 11<sup>th</sup> Jud. Dists. 2007); West Tremont Med. Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 824 N.Y.S. 2d 759 (App. Term, 2d and 11<sup>th</sup> Jud. Dists. 2006). In turn, a provider must

meaningfully rebut the conclusions set forth by the insurer's peer or independent medical examination reviewer. Glenn Segal, PT, PC v. Geico Ins. Co., 44 Misc. 3d 141(A), 997 N.Y.S.2d 668(Table)(App. Term, 2d, 11<sup>th</sup> and 13<sup>th</sup> Jud. Dists. 2014). Where a provider submits evidence demonstrating that its medical services were consistent with generally accepted medical/professional practices, an insurer's peer report may be accorded less weight. All Boro Psychological Servs., P.C. v. Geico Gen. Ins. Co., 34 Misc. 3d 1219(A), 950 N.Y.S.2d 490(Table)(N.Y. City Civ. Ct. Kings. Co. 2012).

**Herein**, Dr. Hip-Flores advises that the surgery in question is performed where imaging studies are inconclusive, where pain continues and where there are functional limitations; he points out that conservative treatment must be afforded an opportunity to favorably benefit the Assignor. In addition, he states that the imaging studies provided a diagnosis. Relatedly, Dr. Hip-Flores notes that the Assignor was advised to engage in treatment, take medication and consider injections; yet, there is no indication that the Assignor engaged in this recommended regimen.

Factually, I find that the Peer Review suffices to rebut the presumption of medical necessity attached to Applicant's claim.

The burden now shifts to Applicant to meaningfully refute the statements in the Peer Review and ultimately establish necessity.

I note at the outset that in AAA Case Number in 17-17-1057-1240, I found that the anesthesia services associated with the surgery were not necessary. However, 17-17-1057-1240 involved a different Applicant [and hence, collateral estoppel does not apply] and there was no Rebuttal. Herein, Applicant proffers a Rebuttal by Alan Dayan, M.D.

Dr. Dayan informs that he saw the Assignor three months post-accident and by then, it was too late to continue with active physical therapy; he relates, the Assignor had pain in the left shoulder, decreased range of motion and various positive tests, such as the Impingement, Neer and Hawkins. He additionally informs that the surgery in question is warranted where, as in the Assignor's case, there is a rotator cuff tear, bursitis or impingement.

I find that Dr. Dayan meaningfully addresses each of Dr. Hip-Flores' dispositive points. In addition, he correlates the standard of care for the performance of the surgery to the Assignor's individual medical picture. Based on the Rebuttal, I do not find that there was any deviation from the standard of care.

I have read Dr. Hip-Flores' Addendum but do not find that it overcomes the strength of the Rebuttal.

### **FEE SCHEDULE**

Although a defense based on Fee Schedule, for services rendered on or after April 1, 2013, is now a non-precludable defense, it remains an insurer-Respondent's burden to establish that the fees charged by a provider-Applicant exceed the amounts set forth in

the appropriate Fee Schedule. Liberty Chiropractic, P.C. v. 21<sup>st</sup> Century Ins. Co., 53 Misc.3d 133(A)2016 WL 5921834 (Table)2016 N.Y. Slip Op. 51409(U)(App. Term, 2d, 11<sup>th</sup> and 13<sup>th</sup> Jud. Dists. 2016)(citing Rogy Med., P.C. v. Mercury Cas. Co., 23 Misc.3d 132(A)885 N.Y.S.2d 713 (Table)(App. Term, 2d, 11<sup>th</sup> and 13<sup>th</sup> Jud. Dists. 2009). It is the insurer's burden to come forward with "competent evidentiary proof" supporting its fee schedule defenses. Robert Physical Therapy, P.C. v. State Farm Mut. Auto. Ins. Co., 13 Misc. 3d 172, 822 N.Y.S.2d 378 (Civ. Ct. Kings. Co. 2006).

A proper denial of claim must include the information called for in the prescribed denial of claim form and must "promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated." Nyack Hosp. v. State Farm Mut. Auto Ins. Co., 11 A.D.3d 664, 784 N.Y.S.2d 136 (2d Dept. 2004)[internal citations omitted]. Moreover, "[a] timely denial alone does not avoid preclusion where said denial is factually insufficient, conclusory, vague or otherwise involves a defense which has no merit as a matter of law." Id.

Further, as my colleague, Arbitrator Michael Korshin, stated, in AAA Case Number 17-16-1029-7778,

"An insurer's unilateral decision to change an applicant's CPT codes, deny the claim, or pay reduced fees for disputed medical services is ineffectual when unsupported by a peer review report or by other proof setting forth a **sufficiently detailed factual basis** and medical rationale for the code changes, denials, and fee reductions."

**Herein**, Respondent presents a document from "techsource," which is similar to an Explanation of Benefits.

I find that the basis for reduction is vague and indiscernible. There is no identification of the referenced fee schedule or pertinent sections of such fee schedule. I deem the techsource document factually insufficient to carry Respondent's burden. In addition, this document is neither signed nor sworn to. I find that it does not constitute a fee coder's Affidavit or Analysis.

Without an Affidavit from a fee coder or peer reviewer, the Arbitrator cannot uphold Respondent's reductions. See, Gentle Acupuncture, P.C. v. Tri-State Consumer Ins. Co., 55 Misc. 3d 147(A), 58 N.Y.S.3d 873(Table) (App. Term, 9<sup>th</sup> and 10<sup>th</sup> Jud. Dists. 2017).

It improper for the Arbitrator to speculate or engage in a Fee Schedule analysis, and because this document, alone, is insufficient, herein, the Arbitrator requires either a Fee Coder's or peer reviewer's analysis. It remains at all times, the Respondent's burden to substantiate its Fee Schedule defense. Factually, I do not find Respondent has met its prima facie burden. Therefore, I award Applicant's claim as sought, in the amended amount of \$ 2,509.13.

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
	Alan J Dayan M.D.	10/16/16 - 10/16/16	\$5,121.81	\$2,509.13	Awarded: \$2,509.13
Total			\$5,121.81		Awarded: \$2,509.13

- B. The insurer shall also compute and pay the applicant interest set forth below. 10/16/2017 is the date that interest shall accrue from. This 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. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 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

As this matter was filed after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 11 NYCRR 65-4.6(d)." This amendment takes into account that the maximum attorney fee has been raised from \$850.00 to \$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, Giovanna Tuttolomondo, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

11/11/2018  
(Dated)

Giovanna Tuttolomondo

**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:**  
38925d5de7b61b97706694688c4144b3

### **Electronically Signed**

Your name: Giovanna Tuttolomondo  
Signed on: 11/11/2018