American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

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| New Horizon Surgical Center LLC (Applicant) | AAA Case No. | 17-18-1109-6875 |
| | Applicant's File No. | STLG18-40591 |
| - and - | Insurer's Claim File No. | 0480216365 |
| | NAIC No. | 19232 |
| Allstate Insurance Company (Respondent) | | |

**ARBITRATION AWARD**

I, James Hogan, 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: EIP

1. Hearing(s) held on 04/18/2019
   Declared closed by the arbitrator on 04/18/2019

   Colleen Terry from Strauss Terry Law Group, PLLC 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, **$ 14,642.25**, 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

   The EIP, a 61 year old male, was injured in a collision on 10/29/17. He was a pedestrian. This claim is for a facility fee for left shoulder surgery performed by Richard Seldes, MD, at the Applicant on 3/19/18 billed at $13,470.99 and a charge for a brachial plexus nerve block injection under ultrasonic guidance administered by Edward Eaton, MD at the Applicant on 3/19/18 and billed at $1,171.26. The Applicant's charges total $14,642.25.

   The Respondent's initial position was that the Applicant's claim was not ripe for arbitration as there were verification requests outstanding. Respondent refers to its letters wearing the request additional verification dated 4/12/18 and 5/17/18.

Respondent has provided a copy of the Declaration Page for the underlying policy. It indicates that there is mandatory PIP of $50,000; OBEL of $25,000 and APIP of $50,000.

Respondent has provided a PIP Ledger indicating that it has spent $75,000.00 on the EIP's claims. Respondent's counsel argues that the policy has been exhausted.

In a Supplemental Submission, the Respondent uploaded a copy of the police accident report showing that the EIP was a pedestrian.

In a late submission, the Applicant uploaded a Memorandum of Law dealing with policy exhaustion.

4. Findings, Conclusions, and Basis Therefor

This decision is based upon my review of the electronic file maintained by the American Arbitration Association, and the arguments of the parties set forth in the hearing.

**SUMMARY OF THE CASE:**

The EIP, a 61 year old male, was injured in a collision on 10/29/17. He was a pedestrian. This claim is for a facility fee for left shoulder surgery performed by Richard Seldes, MD, at the Applicant on 3/19/18 billed at $13,470.99 and a charge for a brachial plexus nerve block injection under ultrasonic guidance administered by Edward Eaton, MD at the Applicant on 3/19/18 and billed at $1,171.26. The Applicant's charges total $14,642.25.

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In a Supplemental Submission, the Respondent uploaded a copy of the police accident report showing that the EIP was a pedestrian.

In a late submission, the Applicant uploaded a Memorandum of Law dealing with policy exhaustion.

**Applicant's submission:**

The Applicant has provided a copy of its billing. (see above)

The Applicant's submission contains documentation generated for the EIP's admission on 3/19/18. These include the anesthesia record.

Also provided is a Peri-Operative Block Record which indicates that an injection was administered to the brachial plexus under ultrasound guidance on 3/19/18.

There is an Operative Report for the left shoulder surgery performed on the EIP on 3/19/18 by Dr. Seldes at the Applicant.

**Applicant's submission contains correspondence from the Respondent dated 4/12/18.** Respondent references Applicant billing for 3/19/18 in the amount of $14,642.25. This billing was received on 4/2/18.

Respondent advises that the Applicant billing is delayed pending a number of items including the EUO of the EIP. In addition, Respondent is asking the Applicant for 8 items.

This letter carries a 120 day warning. A copy of the letter was sent to the EIP and his attorney as well as respondents attorney.

**On 5/16/18, Applicant sent a letter to the Respondent.** Applicant objects to the reasonableness and necessity of the information and documentation requested in order to process the Applicant's no-fault claim for services rendered to the EIP.

It notes that the Applicant is licensed by the state of New Jersey and certified by Medicare and Medicaid. It is subject to inspection by both agencies and is currently licensed by both agencies. It is not required to submit to Respondent's updates as to its ownership and disputes the necessity for that information to process the Applicant's claim regarding the EIP.

In addition, it is irrelevant as to how the EIP was transported to the facility for the services rendered.

Applicant refers to a 2001 court decision from the Supreme Court, Nassau County in the matter of *Westchester Medical Center v. Travelers Property & Casualty Co.*, 2001 NY Slip Op 50082(U) which says the appropriate purpose of the verification request is to obtain such information as necessary to verify and process the claim. The scope of such request is not unlimited; indeed, the service of overly broad and burdensome document demands on healthcare provider, such as those made by Allstate here, are contrary to the Fair Claims Practice Principles, which include (i) prompt and fair payment; (ii) assisting in processing of the claim and that treating the Applicant as an adversary; (III) only demanding verification on practical. (11 NYCRR 65-2.2)

This letter cites 2 other case law which delineates the basis for an insured to make a request for additional verification.

Applicant notes that the current list and disclosure of owners can be found at its website.

Applicant has previously provided a response to discovery presented by Respondent's counsel, Short & Billy, PC in 2005 and all owners are listed on the website.

It appears that the Applicant appeared for an EUO as it refers to the EUO transcript pages with regard to the New Jersey fee schedule.

As to the Respondent's request for an insurance policy, Applicant claims that Allstate is already in possession of the policy, and this demand was designed solely to harass the Applicant and delay payment of the claim.

Applicant again argues against the Respondent's request for information regarding transportation of the patient to the Applicant for services provided. Such information is not relevant to the instant claim.

Applicant also argues that the Respondent is requesting information from the Applicant that is not necessary to process the claim and in support of this position, Applicant refers to a number of the Insurance Regulations, 65-3.2(b), 65-3.2(c); 65-3.2(e); 65-3.8(a)(1) and 65-3.2(f). Applicant claims that it has already provided information to the Respondent and that the continued request for that information violates the aforementioned Regulations.

**On 5/17/18, Respondent sent another letter to the Applicant.** This letter is, essentially, a duplicate of the Applicant's 4/12/18 letter.

**On 6/5/18, Applicant sent another letter to the Respondent.** This letter is, essentially a duplicate of Applicant's 5/16/18 letter. it contains the same attachments.

**On 7/11/18, Applicant's counsel, Strauss Terry Law Group, PLLC, (hereinafter Strauss) sent a letter to Respondent's counsel Short & Billy**, **(hereinafter Short)** in which it acknowledges receipt of Short's letter dated 7/2/18. Strauss objected to the information/ documentation requested as unnecessary and unreasonable to process the Applicant's no-fault claims. This letter argues point by point as to why the requests are objected to. It also cites the various sections of the Insurance Regulations in support of its arguments. It notes that the Applicant appeared for an EUO.

Copies of documents have been provided. These include documents generated for the 3/19/18 encounter of the EIP at the Applicant including the operative report.

**On 8/20/18, Strauss sent another letter to Short, this one referencing Short's letter of 7/13/18.** Applicant objects to the information requested as unreasonable and unnecessary to process its claims. Counsel argues that shorts request for additional

information has nothing to do with the services provided by the Applicant regarding the EIP.

**On 9/4/18, Strauss sent another letter to Short, this one referencing Short's letter of 8/3/18.**

This letter is very similar to the Strauss letter dated 8/20/18. Strauss objects to Allstate's demands for additional verification. Counsel sites to certain Insurance Regulations in support of its arguments.

**The Applicant's submission contains a copy of a letter from the Short firm dated 3/17/14**; copies of an **EUO transcript of the Applicant done on 6/11/14** (109 pages of testimony); copies of correspondence from the then counsel for the Applicant, Jeffrey Rudolph dated 11/21/14 to Short, wherein counsel is objecting to some of Respondent's request for additional verification. In addition, copies of documents have been provided.

**There are copies of letters from the Short firm to the Applicant dated 10/8/14, 10/13/14, and 3/10/15.**

**Also provided is a copy of letter from Stephen Strauss to the Short firm dated 3/24/15** which includes copies of documents requested, including copies of the New Jersey fee schedule.

**On 4/22/15, Short sent a letter to Strauss requesting additional verification after the 6/11/14 EUO of the Applicant.**

**On 4/30/15, Strauss responded to the Short letter objecting to the request for additional verification.** This letter does contain copies of documents from the Applicant.

**On 7/27/15, Strauss sent a letter to Short with a copy of an agreement between Applicant and Horizon Anesthesia, PC and Synergy.** A copy of that agreement is attached.

**In an email dated 11/3/15, Applicant sent a copy of the Waiting Room Disclosure Notice to Allstate's counsel.**

**In an email dated 11/4/15, Applicant's counsel indicates that a copy of an agreement between Applicant and Horizon Anesthesia Group has been sent via the US Mail to the Short firm.**

**The Applicant submission contains copies of arbitration decisions in support of its contentions.**

**Respondent's submission:**

The Respondent's initial position was that the Applicant's claim was not ripe for arbitration as there are verification requests outstanding. Respondent refers to its letters wearing the request additional verification dated 4/12/18 and 5/17/18.

In a Supplemental Submission, the Respondent uploaded a copy of the police accident report which shows that the EIP was a pedestrian.

Respondent has provided a copy of the declaration page for the underlying policy. It indicates that there is mandatory PIP of $50,000; OBEL of $25,000 and APIP of $50,000.

Respondent has provided a PIP Ledger indicating that it has spent $75,000.00 on the EIP's claims. Respondent's counsel argues that the policy has been exhausted.

In addition, Respondent argues that the Applicant has failed to respond to Respondent's requests for additional verification. It argues that until such time that those requests are received, there is no obligation to pay or deny the Applicant's claims.

In its cover letter, Respondent's counsel argues that its requests for additional verification were appropriate. The Respondent is entitled to know who owns the Applicant. As per the Applicant website, Dr. Seldes, the orthopedic surgeon who performed the surgery that is the subject of this claim is an owner of the Applicant.

Responded requested disclosure of the financial relationship with the referring provider but this has not been provided by the Applicant.

The financial relationship between Dr. Seldes and the EIP should be disclosed, and not just posted on the wall. In support of this statement counts refers to PHL 238-d. Respondent also refers to PHL 238(3) regarding a "compensation agreement."

As to radiology services, self-referrals are forbidden in the absence of full disclosure of such self-referral to the patient. Counsel argues that such an act serves as preclusion to payment for no-fault benefits.

"A violation of the statute is a complete defense to a claim for payment of the medical services, and is a non-precluded will defense." Counsel cites to 3 cases in support of this statement.

The Short firm also argues that a violation of PHL section 238-a is akin to the Stark Law, and that the provider as a burden to demonstrate that it is not covered by that law.

Counsel also argues that under the New Jersey Statutes disclosure must be made to patients. The restrictions on referrals of patients established in section 45:9-22.5 of N.J.S.A., section c, subdivision 3 refers to ambulatory surgery or procedures requiring anesthesia performed at a surgical practice registered with the Department of Health or at an ambulatory care facility if the following conditions are met: a) the practitioner

provides a referral personally performs a procedure; b) the practitioners remuneration as an owner or an investor in the practice or facility is directly proportional to the practitioner's ownership interest and not to the violent patients the practice refers to the practice or facility; c) or clinically related decisions at a facility owned in part by non-practitioners are made by practitioners and are in the best interest of the patient and d) disclosure of the referring practitioners 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 provision of section 3 of P.L. 1989, c. 19 (C.45:9-22.6).

Counsel argues that disclosure shall be prescribed by the State Board of Medical Examiners and it does not exclude ambulatory care facilities from requirement of disclosure of ownership interest of a referring physician with the ambulatory care facility.

Respondent claims that the Applicant argues that New York self-referral law does not apply because the Applicant is not a "Practitioner." Respondent argues that the Applicant is a provider as Dr. Seldes is a physician.

Respondent argues that the PHL does not regulate referrals from healthcare providers to practitioners, it regulates referrals from practitioners like Dr. Seldes to healthcare providers such as the Applicant. Dr. Seldes provided services and brought the EIP to the Applicant. Dr. Seldes is, admittedly, an owner of the Applicant.

Respondent refers to the EUO transcript of the Applicant as to disclosure made by Dr. Seldes to his patients. Testimony was provided by Amaury L. Romero, the Administrator at New Horizon Surgical Center, LLC. He testified that one of the owners of the Applicant is Tony Degradi, who is a businessman. ASAR Heathcare is also an owner of the Applicant. Felix Kogan is an owner of that company. Dr. Seldes is an owner of Blue Water Management. Another owner of the Applicant is AFC Investment Services and Amanda Chavez. In addition, Gino Ramundo, DC, has an ownership position in the Applicant.

Dr. Seldes sees his own patients at the Applicant. When asked if the Applicant discloses to patients that Dr. Seldes, who is performing the procedure, also possesses an ownership interest in New Horizon, Mr. Romero says that as per the New Jersey Department of Health "we are required to post a sign to the patients, so they are aware and we do have a sign in the waiting room. I also informed Dr. Seldes that he is required, upon booking a patient, that he lets them know that he has a financial interest in the facility."

A list of the owners of the facility was provided and it is posted in the waiting room, and it has the paragraph that as per the New Jersey Department of Health disclosure that referring physicians may have an interest in the facility. No disclosure is made by the facility to the individual patients.

As per the Respondent, it is incumbent upon Dr. Seldes to comply with the disclosure notice and to inform the patients of his ownership interest in the Applicant. Failing to do so, as per the Respondent, that claim would be in violation of the New Jersey

self-referral prohibition in the claim of the provider as a result of the improper referral is not payable under no-fault. Respondent has referenced a number of cases in support of that contention.

As per Respondent, Applicant argued that the Respondent's position could not be raised without a denial of claim. However, Respondent cites to case law disagreeing with that assertion.

Respondent also argues that Title 45 of NJSA mandates that disclosure of the referring practitioner's significant beneficial interest in the practice or facility should be made to the patient in writing, at or prior to the time that the referral is made. As per Respondent, this condition has not been met in the instant case.

**Respondent's submission also contains:**

Copy of a letter from Strauss to Short dated 12/2/15 which lists the owners of the Applicant and the date that they became owners. Also provided is a copy of the Disclosure Notice of the Applicant.

The Respondent submission contains copies of a cover letter from Applicant's counsel dated 11/8/16 referencing an arbitration between Applicant and Respondent for different EIP and a different arbitration case number. Attached to this letter or documents from New Jersey.

Copies of the Applicant's request for additional verification dated 4/12/18 and 5/17/18.

Copy of correspondence from the Short firm to the Applicant dated 7/2/18;

Copy of correspondence to the Respondent from the Applicant data 5/16/18, with documents attached.

Copy of correspondence from the Short firm to Applicant dated 6/5/18 and 7/13/18, with documents attached.

Copy of correspondence from the Short firm to Strauss referencing the Strauss letter of 7/11/18. Respondent's counsel argues that a number of items are still outstanding. This includes questions as to the ownership of the Applicant, financial relationship with referring providers, disclosure of financial relationship to the patient, regular payment to the owners and other items.

Letter from the Strauss firm to the Short firm dated 7/11/18 responding to Allstate's verification requests, objecting to same and providing documentation with regard to others. Copies of documents are provided.

Letter from the Short firm to the Strauss firm dated 8/3/18 indicating outstanding items which have been requested. The Strauss letter of 7/11/18 is annexed along with the documents provided.

Letter from the Strauss firm to the Short firm dated 8/20/18 responding to counsel's request for additional verification. Certain documentation has been attached.

Letter from Short to Strauss dated 8/29/18 referencing the Strauss letter of 8/10/18, advising that the response was incomplete and advising the information that was still outstanding.

Letter from Short to Strauss dated 9/14/18 representing the Strauss letter of 9/4/18. Respondent argues that there are still outstanding request for verification including the financial relationship of the referring provider and disclosure of financial relationship to the patient as well as a regular payment to the owners. This letter contains a copy of the 9/4/18 Strauss letter.

Respondent has provided a copy of the Applicant's website.

Respondent has provided a copy of a Certificate of Formation of Safe & Sound Transportation, LLC, which indicates that the Member/Manager is Amaury Romero.

Respondent has provided a copy of the EUO transcript of the Applicant and testimony of Amaury L. Romero.

The Respondent has also provided a copy of Public Health Law Title 2D, section 238-D.

The Respondent's submission contains copies of case law which were referred to by Respondent's counsel in its cover letter.

Respondent has provided a copy of Discovery Demands made in a 2017 court action initiated by the Respondent against the Applicant as a/a/o Lynette Roskoff.

The Respondent has provided copies of discovery demands and court orders in other cases where the courts have directed Applicant to provide answers to the discovery demands, including some instances wherein the court denied Respondent's request for some items in discovery.

The Respondent has provided copies of arbitration decisions in support of its contentions.

**At the hearing:**

The discussion focused upon the fact that the underlying policy has been exhausted.

**FINDINGS:**

The Applicant has established its prima facie case.

The EIP, a 61 year old male, was injured in a collision on 10/29/17. This claim is for a facility fee for left shoulder surgery performed by Richard Seldes, MD, at the Applicant on 3/19/18 billed at $13,470.99 and a charge for a brachial plexus nerve block injection

under ultrasonic guidance administered by Edward Eaton, MD at the Applicant on 3/19/18 and billed at $1,171.26. The Applicant's charges total $14,642.25.

The Respondent's position is that the Applicant's claim is not ripe for arbitration as there are verification requests outstanding. Respondent refers to its letters wearing the request additional verification dated 4/12/18 and 5/17/18.

Respondent has provided a copy of the declaration page for the underlying policy. It indicates that there is mandatory PIP of $50,000; OBEL of $25,000 and APIP of $50,000.

Respondent has provided a PIP Ledger indicating that it has spent $75,000.00 on the EIP's claims. Respondent's counsel argues that the policy has been exhausted.

The Respondent raises 2 points - policy exhaustion; 2) the Applicant has not met the requirements of disclosure of the financial relationship of Dr. Seldes and the Applicant to the EIP, thereby disqualifying him from collecting the claim.

I note that the Respondent has opined that the amount of the Applicant billing exceeds the fee schedule but the Respondent has not submitted a fee audit in that regard.

The police report indicates that the EIP was a pedestrian. As such, he is not entitled to make a claim under the APIP coverage.

Applicant argued that the insurer may not avoid payment of a fully verified No-fault claim by asserting policy exhaustion due to subsequent payments made to other health care providers. It may only assert this defense if the policy has been exhausted at the time the fully verified claim was received by the insurer.

In April, 2015, the Appellate Term, First Department, decided the case of ***Harmonic Physical Therapy, PC v. Praetorian Ins. Co.***, (2015 NY Slip Op 50525 (U), 47 Misc 3d, 137 (A)). The insured demonstrated that the underlying policy limits had been exhausted through payment of no-fault benefits in satisfaction of arbitration awards rendered in favor of other healthcare providers and that such payments were made in compliance with the priority of payment regulation (see 11 NYCRR 65-3.15; Nyack Hosp. v. General Motors Acceptance Corp. 8 NY3d 294 [2007]; New York and Presbyt. Hospital v. Allstate Ins. Co., 28 AD3d 528 [2006]. In this case, the plaintiff contended that it was entitled to be paid notwithstanding the insurer paying other providers who had submitted legitimate claims subsequent to the denial of the plaintiff's claim. The Court held that making such payments "runs counter to the no-fault regulatory scheme, which is designed to promote prompt payment of legitimate claims' (Nyack Hosp v. General Motors Accept. Corp, 8 NY3d at 300.

Then, on 3/29/17, the Appellate Term, 2nd Dept. issued its decision in ***Alleviation Med. Servs., PC v. Allstate Ins. Co.*** 2017 NY Slip Op 27097 [55 Misc 3d 44] The Court noted that policy exhaustion is a defense that could be raised at any time. The Court also referred to Nyack Hosp v. General Motors Acceptance Corp., 8 NY 3d 294 [2007] noting that the Court of Appeals said the no-fault benefits are overdue if not paid within

30 calendar days after receipt of a fully completed claim, and held that the word "claims" as used in 11 NYCRR 65-3.15, the priority of payment regulation, does not encompass claims that are not yet complete because they have not been fully verified in accordance with 11 NYCRR 65-3.5 (b). "In contrast, in the instant case, by denying the claim on May 10, 2011, defendant implicitly declared that the claim at issue was fully verified. As we read *Nyack Hosp.* to hold that fully verify claims are payable in the order they are received (*see* 11 NYCRR 65-3.8 [b][3]; 65-3.15; *Nyack Hosp.* 8 NY3d 294), defendant's argument - that it need not pay the claim at issue because defendant paid other claims if it denied the instant claim, which subsequent payments exhausted the available coverage - lacks merit. (*see* 11 NYCRR 65-3.15; *cf. Nyack Hosp.* 8 NY3d 294; *but see Harmonic Physical Therapy v. Praetorian Ins. Co.* 47 Misc 3d 137 [A], 2015 NY Slip Op 50525[U]{App Term, 1st Dept, 2015). Consequently, defendant has not established its entitlement to summary judgment dismissing the complaint."

As of July, 2017, a motion to reargue ***Alleviation*** is pending before the Appellate Term.

I am very familiar with the Nyack Hospital case.

In ***Alleviation***, the claim was contested. The Appellate Term, 2nd Department, would have the insurers set aside the amount of the plaintiff's claim until such time as a determination was made as to whether, or not, the position of the insurer was demonstrated. This could take years, depending upon whether the plaintiff took the case to arbitration or litigation. In the interim, multiple claims would fall into this category and insurers would be faced with a dilemma of setting up hundreds, if not thousands, of separate accounts for contested claims. This would thwart the purpose of no-fault, which is designed to promote prompt payment of legitimate claims.

As such, my position is that I will rely upon the opinion in the ***Harmonic*** case until a final resolution of this matter has been made.

**As of 2/2/19:** the appeal had not been heard.

This claim is denied based upon policy exhaustion.

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 claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York
SS :
County of Suffolk

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

04/20/2019
(Dated)

James Hogan

**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:**
2053ea0762626b1e25799239b7cd3532

**Electronically Signed**

Your name: James Hogan
Signed on: 04/20/2019