

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

North Shore Family Chiropractic PC
(Applicant)

- and -

American Transit Insurance Company
(Respondent)

AAA Case No. 17-17-1059-0999

Applicant's File No. 95600

Insurer's Claim File No. 790457-02

NAIC No. 16616

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 04/12/2019
Declared closed by the arbitrator on 04/12/2019

Naomi Cohn, Esq. from Ursulova Law Offices P.C. participated in person for the Applicant

Veronica Irwin, Esq. from American Transit Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 2,109.96**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

It was represented and agreed that there are only two issues in controversy:

1. A Workers' Compensation defense
2. A Fee Schedule defense

3. Summary of Issues in Dispute

The Assignor, GV, now a 34-year-old male, was the driver of motor vehicle involved in an accident on August 7, 2016. Thereafter, the Assignor sought medical attention for the injuries sustained in the accident. At issue in this case are claims totaling \$ 2,109.96, representing evaluations, chiropractic treatment and X-Rays performed on the Assignor between August 18, 2016 and November 29, 2016. Respondent raises a Workers' Compensation defense and further presents a defense based on billing in excess of the New York Fee Schedule. These two defenses constitute issues in controversy before the Arbitrator.

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.

WORKERS' COMPENSATION

Respondent's NF-10 states:

"Claimant is eligible for Workers' Comp, as claimant was in the course of employment. As a result this claim must be submitted to the employer's Workers' Compensation carrier."

Within Applicant's submission in MODRIA is a determination [NCEC-101] from the Workers' Compensation Board, dated February 16, 2017, informing that the claim is disallowed [qualifying criteria not met]. Parenthetically, I note that the top of the determination makes reference to date of accident 2/7/17, however, factually, I find this to be a numerical error, since the bottom of the page contains the correct date of accident [8/7/16] and the Assignor's name.

Respondent's counsel argued at the hearing that the Applicant had an obligation to inform Respondent of the determination by the Workers' Compensation Board. Respondent's counsel further argued that had Applicant informed Respondent of the determination, Respondent could have been afforded the opportunity to start the claims process anew and/or rescind its denials.

Although I appreciate Respondent counsel's advocacy, I cannot agree. Foremost, there is no authority for the contention that the Applicant is under an obligation to inform the Respondent of a determination by the Workers' Compensation Board. More dispositive, even if there was such an onus on the Applicant, there is no cited authority for the proposition that Respondent may either rescind its denial or start the claims process anew.

RESPONDENT IS BOUND BY ITS NF-10s

A health care provider-Applicant establishes its prima facie entitlement to No-Fault benefits by submitting proof that its claim, on the statutory billing form, was mailed and received by the insurance company and that payment is overdue. Viviane Etienne Med. Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 14 N.Y.S. 3d 283 (2015).

The Insurance laws and 11 NYCRR 65.3.8(a)(1) and (c) ("The Regulation") require the insurer, within 30 days after a claim is received, to either pay or deny a claim in whole or in part. 65-3.8(a)(1), provides, in pertinent part, that:

No-Fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested pursuant to section 65-3.5 of this subpart.

This 30 day period may be extended or "tolled," by a timely demand by the insurer for further verification of a claim, pursuant to 11 NYCRR 65-3.8(b)(3). The claims procedure for requesting further verification is found in 11 NYCRR 65-3.5 and 65-3.6(b).

Herein, Respondent initially issued NF-10s, confidently asserting that the Assignor was eligible for Workers' Compensation. Respondent proffers no statute or case in support of its assertion that, after denying a claim and receiving an adverse determination from the Workers' Compensation Board, it can reinvent the claims process.

As the Court held in All-County Medical & Diagnostic P.C. v. Progressive Cas. Ins. Co., [Dist. Ct. Nassau 2005], an insurer is "limited to the defenses that were specifically raised in the NF-10. The four corners of the Denial of Claim form, the NF-10, and defenses there stated with a high degree of specificity."

I further find guidance in the Decision of my colleague, Arbitrator Yael Aspir, who decided a similar issue as that presented herein. In AAA Case Number 17-16-1043-0833, Arbitrator Aspir stated, in most pertinent part:

"In dispute are the Applicant's claims for \$3,186.44, for medical supplies provided to the EIP on 09/22/15 through 10/22/15. Respondent timely denied the claim based on the EIP's eligibility for Workers' Comp. Thereafter, when the WC claim was denied, Respondent issued Verification Requests for the bills in dispute. *âThe issue to be determined is whether Respondent is entitled to issue Verification Requests subsequent to issuance of a valid NF-10.*"

-and-

"This claim presents an issue of first impression. Specifically, after issuing a timely NF-10 based on a referral to Workers' Comp, does the ultimate denial by the WC Board "re-start Respondent's clock" to pay or deny the claim?"

At the hearing, counsel for Respondent presented arguments that the initial NF-10 was essentially invalidated by the WC Board's decision, affording Respondent the opportunity to start the claims process anew. He argues that on 03/11/16, when Respondent received notice that WC had denied the claim, it triggered a new time clock, affording Respondent the opportunity to request verification, pay or deny the claim. As verification requests were timely issued on 04/07/16 and 05/12/16, and the requested information has not yet been received, Respondent's position is that the claim is not ripe for arbitration, and should be dismissed without prejudice.

Conversely, Applicant argues that a valid and timely denial was issued, and that the law does not allow for respondent to "rescind" their NF-10 in exchange for another bite of the apple. Therefore, the verification requests issued were untimely, and he argues that the claim is due and owing.

Respondent, upon receipt of the first bill submission, made a choice to deny the claim based on the EIP's eligibility for Workers' Comp benefits. That is their chosen defense, and therefore, they "stand or fall" upon it. They cannot now change the basis of their denial, and choose to go down the path of verification requests instead, due to an unfavorable outcome.

The Regulations provide Respondent with a viable option, which must be utilized prior to issuing a denial of claim and referral to the WC Board, namely the NF-9 form. The record before me does not reflect that Respondent issued the NF-9 form to be completed.

11 NYCRR 65-3.19 Offsets

(c) (1) If any source of workers' compensation benefits, or disability benefits under article 9 of the Workers' Compensation Law, denies liability for payment of benefits, in whole or in part, the insurer responsible for the payment of first-party or additional first-party benefits shall pay benefits without deducting the withheld workers' compensation or disability benefits; provided, however, that the applicant executes a prescribed agreement to pursue workers' compensation or New York State disability benefits (NYS Form N-F 9), which shall obligate the applicant to diligently pursue the claim and to repay first-party benefits equal to the withheld amounts in the event such amounts are eventually paid to the applicant. The insurer is entitled to independent verification of the claim in accordance with this subpart. If the applicant paid an attorney's fee out of the proceeds of the award, pursuant thereto, the amount of the attorney's fee shall be deducted from the repayment.

(2) The insurer should send a copy of the completed agreement to the local district office of the Workers' Compensation Board nearest the applicant's residence. Thereafter, the Workers' Compensation Board will give the insurer notice of the applicant's hearing, so that the insurer may be present. Although the

insurer may not be a party to such hearing, it may submit evidence to the referee and may request that the referee put specific questions to the parties." [emphasis added]

I find, for the reasons expressed above, that Respondent is bound by its NF-10. As the basis for its NF-10 ultimately proved to be improper and/or unsubstantiated, and there being no other preserved defenses, Respondent must pay the claims herein.

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. 21st Century Ins. Co., 53 Misc.3d 133(A)2016 WL 5921834 (Table)2016 N.Y. Slip Op. 51409(U)(App. Term, 2d, 11th and 13th 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, 11th and 13th 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 proffers the Affidavit of Wanda Dominguez, a No-Fault Examiner and Medical Audit Specialist. Ms. Dominguez proffers an analysis of reductions only for dates of service August 18, 2016 through August 30, 2016 [which, she maintains, are payable at \$ 436.57] and dates of service September 1, 2016 through September 29, 2016 [which, she maintains, are payable at \$ 728.28].

I am persuaded that there should be a reduction in payment. I find that Applicant overbilled the claims for the X-Rays [CPT Codes 72040, 72100 and 72070]. With respect to these services, a straightforward application using RVUs and Conversion

Factors [using the Zip Code/Region] evidences that where multiple diagnostic procedures are performed on one given day, payment is at 100% of the highest procedure and 75% of the additional procedures. The CPT Codes, respectively, are individually payable at \$ 65.88, \$ 60.09 and \$ 63.71. However, applying the multi-MRI reduction, the codes are reduced as follows: \$ 65.88 [100%], \$ 45.07 [75%] and \$ 47.78 [75%]. Applicant seems to acknowledge the multi-MRI reduction rule in its NF-3 forms, however, it appears that Applicant initially overbilled the service beyond the Fee Schedule amounts [which should be \$65.88, \$ 60.09 and \$ 63.71].

With respect to the office visit billed under CPT Code 99203, the RVU is \$ 9.47, which, when multiplied by the Conversion Factor of \$ 5.78, yields \$ 54.74. While it is true that there is modifier 25 appended to the service, the maximum amount reimbursable for date of service 8/18/16 is \$ 78.03 [13.5 Unit Rule].

Summarily, after the reductions as set forth above, the total amount due to Applicant is correctly calculated by Ms. Dominguez as \$ 436.57 [for dates of Service August 18, 2016 through August 30, 2016].

I find that Ms. Dominguez aptly discusses the Fee Schedule and its application and that her analysis is supported by a review of the Fee Schedule. The burden shifts to Applicant to refute Ms. Dominguez's contentions. Applicant proffers no rebuttal Affidavit or tangible documentary evidence refuting the reductions.

Similarly, I also find that Ms. Dominguez's reductions for dates of service September 1, 2016 through September 29, 2016 are supported by a reading and application of the Fee Schedule and that the amount payable is \$ 728.28.

Total awarded: \$ 436.57 + \$ 728.28 + \$ 346.80 + 492.10 = \$ 2,003.75

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
	North Shore Family Chiropractic PC	08/18/16 - 11/29/16	\$2,109.96	Awarded: \$2,003.75
Total			\$2,109.96	Awarded: \$2,003.75

B. The insurer shall also compute and pay the applicant interest set forth below. 03/20/2017 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, 906 N.E.2d 1046 (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.

05/12/2019

(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:
4006d96712de1dcfd681159e48c1f33d

Electronically Signed

Your name: Giovanna Tuttolomondo
Signed on: 05/12/2019