American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

New York Spine Specialists (Applicant)	AAA Case No.	17-18-1104-1919
	Applicant's File No.	2121743
- and -	Insurer's Claim File No.	0588462780101012
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Alison Berdnik, 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: Claimant

1. Hearing(s) held on 09/18/2019
   Declared closed by the arbitrator on 09/18/2019

   Gary Pustel, Esq. from Israel, Israel & Purdy, LLP (Great Neck) participated in person for the Applicant

   Marco Carvajal, Esq. from Goldstein & Flecker participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 137.59**, 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 Claimant, FA, a 38-year-old male, was an operator of a motor vehicle involved in an accident on January 2, 2018. At issue in this proceeding is $137.59 as follows: $44.61 which represents the balance of Applicant's claim for an initial examination on May 9, 2018; and $92.98 for a follow-up physical evaluation on September 5, 2018.

   Applicant originally submitted a claim to Respondent in the amount of $148.69 for the office visit on May 9, 2018. Respondent applied a different CPT code to the office visit than that originally billed by Applicant, reimbursed Applicant the amount corresponding to the different code, and denied the balance asserting that the original charge exceeded that permitted under the appropriate fee schedule.

With respect to Applicant's claim for the follow-up evaluation on September 5, 2018, Respondent timely denied the claim based upon an independent medical examination ("IME") by Pierce Ferriter, M.D. performed July 17, 2018, terminating benefits effective July 28, 2018.

The issues presented for determination are:

1) Whether Respondent's denial of the balance of Applicant's claim for the initial evaluation on May 9, 2018 based upon the fee schedule can be sustained; and,

2) Whether the office visit on September 5, 2018 was medically necessary.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses present to testify during the hearing. I have reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

An Applicant establishes its prima facie showing of an entitlement to judgment as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed, received by the Respondent and that payment of no-fault benefits is overdue. *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.2d 742, 774 N.Y.S.2d 564 (2nd Dept. 2005). A facially valid claim has been defined as one that sets forth the name of the patient, date of accident, date of service, description of services rendered and the charges for those services. *See, Vinings Spinal Diagnostic P.C. v. Liberty Mutual Insurance Company*, 186 Misc. 2d 128(A), 784 N.Y.S.2d 918 (2003).

The submission of Respondent's Denial of Claim Form ("NF-10") establishes that Respondent received Applicant's claim and that Respondent has not paid the claim. *Lopes v. Liberty Mutual Ins. Co.*, 24 Misc.3d 127(A), 2009 N.Y. Slip Op. 51279(U), 2009 WL 1799812 (App. Term 2nd, 11th & 13th Dists. Jan. 26, 2009). Thus, Applicant has met its burden in this instance.

DOS May 9, 2018: Fee Schedule

Applicant originally submitted a claim to Respondent in the amount of $148.69 for the office visit on May 9, 2018. Respondent applied a different CPT code to the office visit than that originally billed by Applicant, reimbursed Applicant the amount corresponding to the different code, and denied the balance asserting that the original charge exceeded that permitted under the appropriate fee schedule. Specifically, Applicant billed for the office visit in the amount of $148.69 under CPT code 99204. However, Respondent

changed the code to 99203, reimbursed Applicant $104.08, and denied the balance as follows:

> The Evaluation & Management service reported does not meet the criteria or include the appropriate components for the level of service billed. The code that has been assigned reflects the services that were documented based on the E/M guidelines for the diagnosis/injury sustained. See the New York State Worker's [sic] Compensation Fee Schedule.
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> * * *
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> Based on the information submitted, the procedure code has been changed to more accurately reflect the services rendered.

The rates charged by Applicant must be in accordance with Insurance Law §5108. The services in dispute were performed subsequent to the effective date of the Fourth Amendment to Regulation 68-C (April 1, 2013). 11 NYCRR 65-3.8(g)(1) now states that proof of fact that the amount of loss sustained pursuant to Insurance Law 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for claimed medical services under any circumstances: (i) when the claimed medical services were not provided to an injured party; or (ii) for those claimed medical services that exceed the charges permissible pursuant to Insurance Law 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers.

The language of 11 NYCRR §65-3.8(g)(1) does not place any additional requirement on a medical provider to substantiate the calculation of its fees as part of its prima facie case; the burden of asserting a defense that a provider billed in excess of the fee schedule remains on the insurer, who need not pay the bill if it determines that the bill contravenes the fee schedule. *East Coast Acupuncture, PC v. Hereford Insurance Company*, 51 Misc.3d 441, 26 N.Y.S.3d 441 (Civil Ct. Kings Co. 2016). If respondent needed further documentation or additional information for services billed when there is no specific code in the Workers' Compensation fee schedule the insurer needs to request additional verification in accordance with 11 NYCRR 65-3.5(b). *Bronx Acupuncture Therapy v. Hereford Insurance Company*, 2017 NY Slip Op. 50101(U) (App. Term 2nd Dept. 2017).

However, Respondent maintains the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. *See, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co.*, 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). *See also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co.*, 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were more than the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. *See, Continental*

Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145(A), 819 N.Y.S.2d 847, 2006 N.Y. Slip Op. 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term 1st Dept. *per curiam*, 2006).

In support of its defense, Respondent offers an affidavit by Kathleen McClernon, a Claims Associate and certified professional coder employed by Respondent. Ms. McClernon indicates that she is familiar with the Centers for Medicare & Medicaid Services National Correct Coding Initiative guidelines and general principles for evaluating medical services for the purpose of assigning the correct CPT code, and has analyzed the Applicant's medical reports and documents in support of its claim for the May 9, 2018 physical examination of the Claimant, and concludes that the criteria set forth in CPT code 99203 more accurately reflects the level of E/M services provided by the applicant than does the criteria set forth in CPT code 99204, the CPT code selected by the applicant for the May 9, 2018 physical examination. Specifically, Ms. McClernon states that CPT Code 99203 accurately reflects the level of E/M services as documented by the healthcare provider in the clinical record, which supports a "detailed" history and examination of the patient rather than a "comprehensive" history and examination, and medical decision making of "low" complexity rather than "high" complexity. Ms. McClernon concluded that the documentation in the clinical record did not substantiate more than 30 minutes of face to face time spent by the provider with the patient or her family.

Comparing the relevant evidence submitted by the parties, and upon consideration of the arguments by counsel, I am persuaded by Ms. McClernon's in depth explanation regarding the downcoding of the disputed office visit. Applicant does not submit an affidavit in rebuttal to Respondent's coder affidavit, and I find the affidavit of Kathleen McClernon to be persuasive and credible. Applicant's evaluation report, standing alone, is insufficient to establish the CPT code as billed by Applicant. As such, Respondent's expert affidavit is sufficient to sustain Respondent's burden in establishing its fee schedule defense. Accordingly, Applicant's claim for additional reimbursement in the amount of $44.61 for the physical examination on May 9, 2018 is denied.

DOS September 5, 2018: Medical Necessity

With respect to Applicant's claim for the follow-up evaluation on September 5, 2018, Respondent timely denied the claim based upon an independent medical examination by Pierce Ferriter, M.D. performed July 17, 2018, terminating benefits effective July 28, 2018.

As such, the burden now shifts to the Respondent to prove that the services were not medically necessary. *Amaze Medical Supply v. Eagle Insurance*, 2 Misc.3d 128(A) (2003). Once the Respondent makes a sufficient showing to carry its burden of coming forth with evidence of lack of medical necessity, the Applicant must rebut it. *A. Khodadadi Radiology, P.C. v. NY Central Mutual Fire Insurance*, 16 Misc.3d 131(A), 841 N.Y.S.2d 824 (2007).

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment. *Kingsborough Jewish Med. Ctr. v. All State*

Ins. Co., 61 A.D. 3d. 13 (2nd Dept. 2009). *See also Channel Chiropractic PC v. Country Wide Ins. Co.*, 38 AD 3d. 294 (1st Dept. 2007). If Respondent's denial is premised upon a medical examination, the IME must establish a factual basis and medical rationale for his asserted lack of medical necessity for future health care services. E.g., *Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A)*, (App. Term 2nd & 11th Jud. Dists. Sept. 3, 2008); *Carle Place Chiropractic v. New York Central Mut. Fire Ins. Co.*, 19 Misc.3d 1139(A), (Dist. Ct., Nassau Co., Andrew M. Engle, J., May 29, 2008). Where an IME report provides a factual basis and medical rationale for an opinion that services were not medically necessary, and the claimant fails to present any evidence to refute that showing, the claim should be denied. *AJS Chiropractic, P.C. v. Mercury Ins. Co.*, 22 Misc.3d 133(A), (App. Term 2nd & 11th Jud. Dists. 2002).

At the outset it is noted that Applicant's original AR-1 filed August 25, 2018, included only the balance of its claim for the May 9, 2018 office visit. However, on October 3, 2018, Applicant filed an amended AR-1 adding the claim for the September 5, 2018 reevaluation. Respondent's NF-10 and accompanying Explanation of Benefits ("EOB") denying the claim based upon a lack of medical necessity are included within Applicant's amended submission, and, as such, is sufficient to establish Applicant's *prima facie* entitlement to reimbursement.

According to the documents contained in the electronic case file in MODRIA, on October 4, 2018, the American Arbitration Association sent a Notice of Amendment to Respondent, advising Respondent of Applicant's additional claim for services rendered September 5, 2018, and instructing Respondent to confirm no later than October 5, 2018 its position with respect to the claim. However, to Respondent's detriment, no additional submission has been offered in support of its defense based upon a lack of medical necessity. I have searched the record and am unable to locate Dr. Ferriter's IME report referenced in Respondent's EOB.Therefore,Respondent's denial of Applicant's claim for the reevaluation performed September 5, 2018 is unsupported by the evidence and, as such, cannot be sustained.

Accordingly, Applicant is awarded $92.98 in full satisfaction of its claim.

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**	**Total**	**Status**
	New York Spine Specialists LLP	**05/09/18 - 05/09/18**	**$44.61**	**$ 92.98**	**Denied**
	New York Spine Specialists LLP	**09/05/18 - 09/05/18**	**$92.98**	**$ 92.98**	**Awarded: $92.98**
Total			**$137.59**	**Awarded: $92.98**	

B. The insurer shall also compute and pay the applicant interest set forth below. 10/03/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

With respect to Applicant's claim for services rendered September 5, 2018, Applicant is awarded $92.98, together with applicable interest computed from the date of filing of the amended AR-1 on October 3, 2018 until such time as payment is issued.

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 11 NYCRR 65 - 4.6(d).

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 Suffolk

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

09/19/2019
(Dated)

Alison Berdnik

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:
5b62f71bb966672ba39175de44e995dc

Electronically Signed

Your name: Alison Berdnik
Signed on: 09/19/2019