American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Tandingan PT PC (Applicant)	AAA Case No.	17-18-1094-5859
	Applicant's File No.	DK18-43006
- and -	Insurer's Claim File No.	9RINY05149
	NAIC No.	29742
Integon National Insurance Company (Respondent)		

ARBITRATION AWARD

I, Matthew Brew, 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: Injured Party

1. Hearing(s) held on 03/13/2020
   Declared closed by the arbitrator on 03/13/2020

   Henry Guindi, Esq. from Korsunskiy Legal Group P.C. participated in person for the Applicant

   Joseph Licata, Esq. from Rossillo & Licata LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 2,816.35**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The Parties to Applicant's prima facie case and to the timeliness of Respondent's denials.

   The Parties also stipulated that if Applicant's claim is awarded interest will commence from the filing date of May 9, 2018.

3. Summary of Issues in Dispute

   Whether Respondent established and sustained its lack of medical necessity defense in regard to the services rendered by Applicant between May 26 and July 25, 2017?

Whether Respondent established and sustained its fee schedule defenses in regard to the disputed billings?

4. Findings, Conclusions, and Basis Therefor

Upon comparing all the relevant evidence submitted by the parties as contained in the electronic file maintained by the American Arbitration Association, and in consideration of the oral arguments presented by each party, **I find in favor of the Applicant in the amount of $2,002.51.**

Applicant's assignor, hereinafter referred to as the Injured Party or "IP", is described as a then 39-year-old male passenger of a motor vehicle involved in an accident on May 13, 2017. The IP did not present to a hospital on the date of loss. Rather, the records indicate that the IP initially sought treatment from his chiropractor regarding complaints of pain to his back, neck and knees.

Following his initial treatment, the IP also began a course of conservative care including chiropractic, physical therapy and acupuncture. The IP was also provided certain medical equipment. Nerve testing and other diagnostic tests were also performed.

In this case, Applicant is seeking reimbursement in the amount of $2816.35 in regard to various activity limitation measurement testing, MMT testing and ROM testing performed between May 26 and July 25, 2017. Reimbursement regarding all nine submitted bills was denied based upon Respondent's determination that the treatments were not medically necessary. Respondent also uploaded global denials based on the IP's purported failure to appear for various IMEs. However, this defense was not preserved in any of the claims specific denials is therefore deemed waived.

Respondent also argues that the amounts charged by Applicant exceed the permissible amounts as provided by the applicable fee schedule. The parties stipulated to Applicant's prima facie case and to the timeliness of Respondent's denials.

Medical Necessity

Upon stipulating to the Applicant's prima facie case, the burden shifted to the Respondent to come forward with enough evidence to rebut the presumption of medical necessity that attached to the Applicant's bills. West Tremont Med. Diagnostic, PC v. Geico Ins. Co., 13 Misc.3d 131(A) (N.Y. App. Term 2006). When a Respondent carrier establishes a defense based on a lack of medical necessity the burden shifts back to the provider who then must then come forward with its own evidence of medical necessity. West Tremont Med. Diagnostic, PC v. Geico Ins. Co., Id. However, an insurance carrier must, at a minimum, establish a detailed factual basis and a sufficient medical rationale for asserting the lack of medical necessity defense. Vladimir Zlatnick, M.D. v. Travelers Indem. Co. 2006 NY Slip Op. (50963U) (App. Term 1st Dept., 2006). See also Delta

Diagnostic Radiology PC v. Progressive Casualty Ins. Co. 21 Misc. 3d. (142A) (App. Term 2nd Dept., 2008). Conclusions set forth in peer reviews may be insufficient if the peer review fails to provide specifics of the claim, is conclusory or otherwise lacks a basis in the facts of the claim. Amaze Medical Supply v. All State Ins. Co. 3 Misc. 3d. 43 (App. Term 2nd Dept., 2004).

In this case, Respondent's lack of medical necessity defense was premised upon two separate peer reviews by Dr. Neil M. Ganz, DC both dated November 28, 2017. One peer addressed the ROM/MMT testing and the other the activity limitation measurement testing. Respondent also submitted an addendum from Dr. Ganz dated January 18, 2020 and further relied upon the submitted records and the arguments of counsel.

Upon reviewing applicable records and providing a history of the IP's condition and treatment, Dr. Ganz determined the none of the disputed treatments were medically necessary. I found both Dr. Ganz' peer reviews sufficient in terms of establishing, *prima facie*, Respondent's lack of medical necessity defense in regard to the disputed claims. His ultimate determinations were supported by a "sufficiently detailed factual basis and medical rationale". Carle Place Chiropractic v. New York Central Mut. Fire Ins Co., 19 Misc.3d 1139(A), 866 N.Y.S.2d 90 (Table); Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), 873 N.Y.S.2d 238 (Table). Further, both reports provided specifics of the claim, referenced pertinent authority and did not appear conclusory.

Having established prima facie that the treatment was not medically necessary, the burden shifted to the Applicant to rebut the peer doctor's conclusions and to establish by a preponderance of the evidence the medical necessity for the disputed treatment. West Tremont Med. Diagnostic, PC v. Geico Ins. Co., 13 Misc.3d 131(A) (N.Y. App. Term 2006).

In support of its claim, Applicant submitted a formal rebuttal from Madonna Parungo Tandingan, DPT dated December 21, 2019. Applicant also relied upon the submitted records and the arguments of counsel. In her rebuttal, Ms. Tandingan addressed Dr. Ganz' arguments and outlined her reasons as to why she believed the disputed treatments were medically necessary.

In response to Applicant's rebuttal, Respondent submitted an addendum from Dr. Ganz dated January 18, 2020.

Clearly, this cased involved conflicting opinions as to whether the disputed treatments were medically necessary. After carefully reviewing the applicable evidence, and in contemplation of the arguments presented by counsel during the hearing, I find Applicant's evidence more persuasive on the issue of whether the disputed treatments were necessary. In the opinion of the undersigned, the submitted records in conjunction with Applicant's rebuttal sufficiently rebutted Respondent's prima facie showing. I also find that Applicant satisfied its burden in terms of establishing by a preponderance of the evidence the medical need for the disputed treatments.

Therefore, based on the foregoing, I find Applicant is entitled to reimbursement in regard to the disputed treatments.

Fee Schedule

Respondent's counsel further argued that even if the treatments were deemed necessary, any amount awarded Applicant must be reduced to comply with the permissible amounts as provided in the applicable fee schedule.

When denying or reducing a claim based upon the charged fees being in excess of the amount permitted by the applicable fee schedule, the Respondent bears the burden of coming forward with "competent evidentiary proof" supporting its defense. Robert Physical Therapy, P.C. v. State Farm Mut. Auto. Ins. Co., 13 Misc. 3d. 172(Civ. Ct. Kings Co. 2006). A lay person is not qualified to evaluate the CPT codes or to change the code utilized by a health provider. See Abraham v. Country-Wide Ins. Co., 3 Misc. 3d. 130A (App. Term 2d. Dept. 2004). The failure to provide such proof can be fatal to Respondent's fee schedule defense. Continental Medical, P.C. v. Travels Indemnity Co., 11 Misc. 3d.145A (App. Term 1st Dept. 2006).

Specifically, I note the following in regard to Respondent's arguments:

Regarding the ALMT testing on May 31, June 26, and July 25, 2017, Applicant billed $475.00 per treatment under code 97799. 97799 is a BR code. Respondent argued that the maximum amount that would be owed per treatment totaled $182.84. However, Respondent failed to submit a supporting affidavit or any persuasive fee audit in support of its claimed reduction. I therefore find that Respondent failed to establish, prima facie, a basis for its claimed reduction.

Applicant is therefore awarded $1,425.00 in response to these three billings.

Regarding service dates of May 26, June 28, and July 24, 2017 Applicant initially billed $198.65, $198.65 and $119.19 respectively for MMT. However, during argument the parties agreed that the maximum amount owed per treatment for service dates of May 26 and June 28, 2017 is $104.18 per service date (assuming the treatment was deemed necessary). The parties disagreed as to the proper amount owed for service date of July 24, 2017 which was billed at $119.19. Respondent maintained that $104.18 is all that was owed for that billing. Applicant argued that it was entitled to $119.94 "because that's what the math provides".

Indeed, the conversion value for 95831 is $5.16. The RV is 7.70. $5.16 x 7.70 is $39.73. $39.73 x 3 units totals $119.19. Respondent did not provide any persuasive argument as to why Applicant was only entitled to $104.18 in regard to this billing.

Applicant is therefore awarded a total of $327.55 in regard to the three MMT disputed in this case.

Regarding the ROM testing on May 26, June 28, July 24, 2017 Applicant initially billed $291.62 per treatment. However, during argument the parties agreed that the maximum amount owed per treatment is $83.32 or $41.66 per extremity (assuming the treatment was deemed necessary).

Applicant is therefore awarded $249.96 regarding the disputed ROM testing.

Conclusion

Based on the foregoing, I find in favor of Applicant in the total amount of $2,002.51.

This decision is in full disposition of all claims for No-Fault benefits submitted before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not specifically raised at the time of hearing.

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**
	Tandingan PT PC	**05/26/17 - 07/25/17**	**$2,816.35**	**Awarded: $2,002.51**

Total	**$2,816.35**	**Awarded: $2,002.51**

B. The insurer shall also compute and pay the applicant interest set forth below. 05/09/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

May 9, 2018 is the date the arbitration is deemed to have been commenced and the date that the parties stipulated interest would accrue from should Applicant prevail.

INTEREST: Pursuant to Insurance Law § 5106 (a), interest accrues on overdue no-fault insurance claims at a rate of 2% per month. A claim is overdue when it is not paid within 30 days after a proper demand is made for its payment (Insurance Law § 5106 [a]; 11 NYCRR 65.15 [g]). The Superintendent's regulation tolls the accumulation of interest if the claimant "does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations" (11 NYCRR 65-3.9 [c]). The Superintendent has interpreted this provision to mandate that the accrual of interest is tolled, regardless of whether the particular denial at issue was timely. That interpretation was upheld by the Court of Appeals in LMK Psychological Servs, P.C. v. State Farm Mut. Auto. Ins. Co., 2009 NY Slip Op 02481 (April 2, 2009). Where no denial of claim is issued in response to a proper demand for payment, the insurer does not benefit from the tolling provision and interest will accrue from the date 30 days after the proper demand for payment is made. Interest that accrues when a denial of claim is not issued within 30 days after the proper demand for payment is made will be tolled upon the issuance of a denial of claim, although such denial is untimely, and the failure to request arbitration or institute a lawsuit within 30 days after receipt of that denial of claim form.

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below

For cases filed after February 4, 2015, the attorney's fee is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4. The attorney's fee shall be limited as follows: 20% of the total amount of first-party benefits and any addition first-party benefits, plus interest thereon, for each applicant per arbitration or court proceeding, subject to a maximum fee of $1,360. If the nature of the dispute results in an attorney's fee that could be computed in accordance with the limitations prescribed in both subdivision (c) and this subdivision, the higher attorney's fee shall be payable.

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

04/06/2020
(Dated)

Matthew Brew

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:
b2a3cefba868f1f2e5a674762fe5a391

Electronically Signed

Your name: Matthew Brew
Signed on: 04/06/2020