

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

PR Medical PC
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-19-1132-0718
Applicant's File No.	161655589
Insurer's Claim File No.	0591528320101020
NAIC No.	35882

ARBITRATION AWARD

I, Maria Schuchmann, 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 12/01/2020
Declared closed by the arbitrator on 12/01/2020

Victoria Tarasova, Esq from Law Offices of Zara Javakov, Esq. P.C. participated in person for the Applicant

Crystal Abreu, Esq from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 2,399.23**, 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

Whether Applicant is entitled to reimbursement for the balance of charges for an office exam, range of motion and muscle testing performed on Claimant on from June 25, 2018 through August 8, 2018 as a result of injuries allegedly sustained in a motor vehicle accident on June 23, 2018 and whether physical therapy from September 13, 2018 through January 16, 2019 was medically necessary..

Respondent has issued a partial payment and has denied the balance based upon fee schedule issues and a change of the codes billed. Payment for the physical therapy was denied based upon the results of an independent medical exam by Dr. Hershon who concluded Claimant did not require any further care.

4. Findings, Conclusions, and Basis Therefor

Claimant was involved in a motor vehicle accident on June 23, 2018. On June 25, 2018 he was initially evaluated at Applicant's facility due to injuries sustained in that accident.

Upon receipt of the bill for the initial exam, Respondent changed the code to reflect a lower category of service and paid Applicant at the reduced rate.

On July 2, 2018 and August 8, 2018 Claimant underwent range of motion and muscle testing at Applicant's facility due to his injuries.

Again, upon receipt of the bill Respondent combined the two codes, changed the code to 97750, a physical performance test claiming that that code better represented the services performed and made a partial payment.

However, Respondent has not submitted any evidence to support the code change and reduction of fees.

In Medical Record Retrieval DBA Kamara Supplies v GEICO Insurance Co., AAA Case No.: 412009033256, decided November 18, 2009, Arbitrator Horn noted that when asserting a fee schedule defense, it is Respondent's duty to submit proof that the charges were excessive. See, Bronx Multi Medical P.C. v Kemper Casualty Ins Co., 21 Misc.3d 127 (App. Term 1st Dep't. 2008).

Without a definitive basis for the fee reduction, the carrier's defense to further reimbursement must fail. Robert Physical Therapy, P.C. v State Farm Mut. Auto Ins. Co., 13 Misc.3d 172 (2006). In this case, the Court held that the respondent must present competent evidentiary proof supporting its fee schedule defense.

The Court stated:

"Defendant's counsel is not competent to opine on whether range of motion and muscle testing is generally included in an office evaluation by a physical therapist. Defendant opted not to commission a peer review and move thereupon for summary judgment, or to proceed to a live trial at which it could present witnesses and evidence. Instead, counsel proceeded only on briefs. In the absence of any testimony by a competent medical professional, this court cannot determine whether plaintiff's charges were medically appropriate. Since it was defendant's burden to make out its defense, the court finds that defendant has failed to carry its burden".

It is settled law that to recover assigned first-party no-fault benefits, a provider establishes a prima facie entitlement to an award by proof of submission of statutory claim forms setting forth the fact and amounts of the losses sustained, and that payment of No-Fault benefits was overdue. (See *Insurance Law 5106(a)*; *Mary Immaculate Hospital v Allstate Ins. Co.*, 5 AD3d 742, 774 NYS2d 564 [2004]). In addition, Respondent's acknowledgement of receipt of the bill in its denial of claims forms is proof of submission of the claim. (see *Careplus Med. Supply Inc. v State-wide Ins. Co.*, 11 Misc 3d 29, 812 NYS2d 736 [App Term, 2nd & 11th Jud Dists 2005]).

The burden then shifts to Respondent for proof of any defenses, including causality, adherence to the fee schedule and medical necessity.

In this case, Respondent has failed to submit any proof that the CPT codes were properly changed and that the fee reduction was proper.

First, Applicant is entitled to reimbursement for the balance of the office visit in the amount of \$44.61.

Based upon a plain reading of the fee schedule, Applicant is entitled to further reimbursement for the range of motion and muscle testing in the amount of \$43.58 for each of the two days.

With respect to the therapy at issue, Respondent has denied payment for all services after September 2, 2018 based upon the results of an independent medical examination performed by Dr. Hershon on August 22, 2018 that concluded that Claimant did not require any further treatment.

That report indicates that a complete examination was performed by Dr. Hershon that elicited all normal results. After reviewing that report I have no reason to question his opinion with respect to Claimant's need for further treatment or testing.

It is now well settled that Applicant establishes "a prima facie showing of their entitlement to judgment as matter of law by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the amount of the loss sustained] had been mailed and received and that payment of no-fault benefits were overdue." *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). In the case at bar, Applicant has met this burden.

Once Applicant has established a prima facie case the burden is on the insurer to prove that the medical treatment was not medically unnecessary. See, *Citywide Social Work & Psychological Services, PLLC a/a/o Gloria Zhune v. Allstate Ins. Co.*, 8 Misc.3d 1025A, 806 N.Y.S.2d 444 (App. Term 1st Dept. 2005); *A.B. Medical Services, PLLC v. Geico Ins. Co.*, 2 Misc 3d 26, 773 N.Y.S.2d 773 (App Term 2nd & 11th Jud Dist 2003).

Lack of medical necessity is a valid defense to an action to recover No-Fault benefits, *Countrywide Ins. Co. v. 563 Grand Med., P.C.*, 50 A.D.3d 313 (1st Dept. 2008); *A.B. Med. Servs., PLLC v. Liberty Mut. Ins. Co.*, 39 A.D.3d 779 (2d Dept. 2007), if raised in

a denial that is (1) timely, *Presbyterian Hosp. in the City of New York v. Maryland Casualty Ins. Co.*, 226 A.D.2d 613 (2d Dept. 1996); *Central Gen. Hosp. v. Chubb Group of Ins. Co.*, 90 N.Y.2d 195 (1997), (2) includes the information called for in the prescribed denial of claim form, 11 NYCRR § 65-3.4 (c) (11); *Nyack Hosp. v. Metropolitan Prop. & Cas. Ins. Co.*, 16 A.D.3d 564 (2d Dept. 2005); *Nyack Hosp. v. State Farm Mut. Auto. Ins. Co.*, 2004 WL 2394038, 2004 NY Slip Op 07663 (2d Dept. Oct. 25, 2004); *Summit psychological, P.C. v. General Assur. Co.*, 9 Misc.3d 8, (App Term 9th & 10th Jud Dists., 2005); *Shtarkman v. Allstate Ins. Co.*, 8 Misc.3d 129(A), 2005 NY Slip Op 51028(U) (App Term 2d & 11th Jud Dists.), and (3) "promptly apprise(s) the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated", *General Accident Ins. Group v. Cirucci*, 46 N.Y.2d 862, 864, 414 N.Y.S.2d 512, 387 N.E.2d 223 (1979); *New York University Hosp. Rusk Ins. v. Hartford Acc. & Indem. Co.*, 32 A.D.3d 458, 2006 NY Slip Op 06223 (2d Dept. 2006).

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, *Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co.*, 2009 NY Slip Op 00351 (App Div 2d Dept., Jan. 20, 2009); *Channel Chiropractic, P.C. v. Country- Wide Ins. Co.*, 2007 Slip Op 01973, 38 A.D.3d 294 (1st Dept. 2007); *Bronx Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co.*, 2007 NY Slip Op 27427, 17 Misc.3d 97 (App Term 1st Dept., 2007), such as by a qualified expert performing an independent medical examination, conducting a peer review of the injured person's treatment, or reconstructing the accident. *Id.*

An insurance carrier must, at a minimum, establish a detailed factual basis and a sufficient medical rationale for its asserted lack of medical necessity. *Vladimir Zlatnick, M.D., P.C. v. Travelers Indem. Co.*, 2006 NY Slip Op 50963(U) (App Term 1st Dept., 2006); *Delta Diagnostic Radiology, P.C. v. Progressive Casualty Ins. Co.*, 2008 Slip Op 52450(U), 21 Misc.3d 142(A) (App Term 2d Dept., 2008).

Respondent has met its burden in this case. The IME noted all normal findings.

Though Applicant has submitted a rebuttal by Dr. Hirsch, I find it unpersuasive. The report itself is vague and gives no exact range of motion measurements. In fact, the exam, itself, was scant and incomplete.

After a review of all of the evidence, I find that the therapy at issue was not medically necessary.

Accordingly, this portion of the claim is denied in its entirety.

Accordingly, this claim is granted in the amount of \$131.77 plus applicable interest computed from the date the AR-1 was filed until the date of payment. Applicant is also awarded statutory attorney's fees on the amount awarded herein plus the interest, as well as return of the filing fee.

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
	PR Medical PC	06/25/18 - 06/25/18	\$44.61	Awarded: \$44.61
	PR Medical PC	07/02/18 - 07/02/18	\$87.18	Awarded: \$43.58
	PR Medical PC	08/08/18 - 08/08/18	\$87.18	Awarded: \$43.58
	PR Medical PC	09/13/18 - 09/13/18	\$64.07	Denied
	PR Medical PC	09/13/18 - 09/13/18	\$204.41	Denied
	PR Medical PC	09/14/18 - 09/14/18	\$178.62	Denied

	PR Medical PC	09/11/18 - 09/20/18	\$202.80	Denied
	PR Medical PC	10/02/18 - 10/11/18	\$338.00	Denied
	PR Medical PC	10/22/18 - 10/22/18	\$64.07	Denied
	PR Medical PC	10/16/18 - 10/31/18	\$338.00	Denied
	PR Medical PC	11/01/18 - 11/08/18	\$270.40	Denied
	PR Medical PC	11/21/18 - 11/21/18	\$64.07	Denied
	PR Medical PC	11/20/18 - 11/29/18	\$202.80	Denied
	PR Medical PC	12/04/18 - 12/11/18	\$202.80	Denied
	PR Medical PC	01/16/19 - 01/16/19	\$50.22	Denied
Total			\$2,399.23	Awarded: \$131.77

B. The insurer shall also compute and pay the applicant interest set forth below. 06/13/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

this claim is granted in the amount of \$131.77 plus applicable interest computed from the date the AR-1 was filed until the date of payment.

C. Attorney's Fees

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

Applicant is also awarded statutory attorney's fees on the amount awarded herein plus the interest, as well as return of the filing fee.

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

12/01/2020
(Dated)

Maria Schuchmann

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:
c1ebe3a5814bc75d37126c99cfb8e4f7

Electronically Signed

Your name: Maria Schuchmann
Signed on: 12/01/2020