

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Citimed Services, PA
(Applicant)

- and -

Avis Budget Group
(Respondent)

AAA Case No. 17-19-1123-6292

Applicant's File No. FL19-44049

Insurer's Claim File No. 178031985-001

NAIC No. Self-Insured

ARBITRATION AWARD

I, Gerry Wendrovsky, 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 02/10/2021
Declared closed by the arbitrator on 02/10/2021

Nancy Orłowski from Field Law Group, P.C. participated in person for the Applicant

Deena Khalifa from Rubin, Fiorella, Friedman & Mercante LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,452.18**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant amended its claim to \$762.53, asserting same was in accordance with the relevant fee schedule.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The EIP, AL, a 19 year old female, was involved in a motor vehicle accident on 7/7/17. At issue is \$1,452.18 for services rendered on 10/31/18. A denial was not issued. The question presented is whether the services were billed in accordance with the applicable fee schedule.

4. Findings, Conclusions, and Basis Therefor

This case has been 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. I have reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon. This decision is in full disposition of the issues before me.

At the hearing, applicant amended its claim to \$762.53, asserting same was in accordance with the relevant fee schedule.

An applicant establishes its *prima facie* entitlement to judgment as a matter of law by proof that it submitted a claim, setting forth the fact and the amount of the loss sustained, and that payment of no-fault benefits was overdue. *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 A.D. 3d 742 (2nd Dept., 2004). Applicant has submitted sufficient credible evidence to establish its *prima facie* case.

No Denial

Applicant uploaded proof of mailing of the bill (dated 11/28/18), consisting of a certificate of mailing bearing a USPS postmark dated 11/29/18, the EIP's name, DOS and sum sought.

It is well settled, where an applicant demonstrates its bill was mailed to respondent, a presumption arises that the NF-3 was received by the insurer. *Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co.*, 25 N.Y. 3d 498, 508-509 (2015). The presumption may be rebutted where respondent both avers that it has no record of having received a particular claim, and sufficiently describes its procedures for the receipt of mail. *Compas Medical, P.C. v. Nationwide Ins.*, 46 Misc. 3d 131(A) (App. Term 2014).

Herein, respondent has not satisfied either prong of the *Compas* standard; as respondent has not rebutted the presumption, I find applicant established its *prima facie* proof of mailing of the bill.

Fee Schedule

Applicant billed (prior to amendment) \$879.37 under cpt 62323 and \$572.81 under cpt 72275.

I have taken judicial notice of the New York and New Jersey fee schedule. *Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co.*, 61 A.D. 3d 13, 20 (2nd Dept., 2009).

Respondent had the burden of coming forward with competent evidentiary proof to support its fee schedule defense. *Robert Physical Therapy, P.C. v. State Farm Mut. Auto. Ins. Co.*, 13 Misc. 3d 172 (Civ. Ct. 2006). In the absence of such proof,

respondent's defense cannot be sustained. Continental Medical, P.C. v. Travelers Indem. Co., 11 Misc. 3d. 145(A) (App Term 2006).

Initially, I observe the 33rd Amendment, 11 NYCRR 68 (Insurance Regulation 83) effective 1/23/18, may apply as the EIP was a New York resident, and the bill set forth the services were rendered in New Jersey; the regulation, *inter alia*, requires that where applicable, the lesser of the New York or New Jersey fee schedule should be the sum reimbursed (33rd Amendment).

I further note, that for ambulatory surgery rendered in New York on or after 10/1/15, the NYS WCB has adopted the methodology for calculating ambulatory surgical centers and hospital-based ambulatory surgery services based on EAPG. 12 NYCRR 39-2.1.

At the hearing, it was ascertained the subject services were performed in New Jersey; respondent argued that at the most, applicant was entitled to reimbursement of \$182.38.

Respondent's submission (including the New Jersey fee schedule) asserted in relevant part:

".... applicant seeks reimbursement for anesthesia treatment provided in New Jersey Ambulatory Surgery Center Pursuant to New Jersey Fee Schedule Rules 11:3-29.5 (a), the billed CPT code(s) are not reimbursable under the New Jersey Fee Schedule Pursuant to 11:3-29.5 (a), Outpatient surgical facility fees (a) ASC facility fees are listed in Appendix Codes that do not have an amount in the ASC facility fee column are not reimbursable if performed in an ASC. The ASC facility fee include services that would be covered if the services were furnished in a hospital on an inpatient or outpatient basis, including: 7. Anesthesia materials, including the anesthetic itself, and any materials, whether disposable or re-usable, necessary for its administration; CPT 62323 is not even listed on the NJ Fee Schedule.... The claim should be denied in its entirety (under 33rd Amendment) the NY fee schedule (conversion factor for Anesthesia in Region IV) = \$27.01 x 7 units = \$189.07..."

I observe the New Jersey fee schedule (NJFS) reflects the omission of cpt 62323, but which may be subject to a code 'crosswalking'.

Applicant's submission referenced an (unrelated) award, and the NJFS (North), that reflected no reimbursement for cpt 72275.

Discussion

I have previously heard argument (involving the 33rd Amendment) to the effect that as cpt 72275 lacked a fee amount, it was not reimbursable if performed in an ambulatory facility [NJCA 11:3-29.5(a)]; and that as a cpt (E.g., 62321) did not appear anywhere in

the fee schedule, a New Jersey ambulatory facility (ASC) could not be reimbursed for such an unlisted code, citing *New Jersey Manufacturers Insurance Company v. Specialty Center of North Brunswick*, 203 A.3d 672 (N.J. App. Div. 2019).

In *New Jersey Manufacturers*, *supra*, the court addressed two arbitrated matters involving a different code (cpt 63030), which the NJFS did not list "*as a code eligible for reimbursement for physicians or ASCs*". The Court noted in pertinent part:

".... if the CPT code is listed and no amount is set forth for an ASC, the ASC cannot receive payment for that service"

I have also reviewed a master arbitration award (AAA# 99-18-1103-7037) concerning reimbursement for services rendered at an ASC for another unlisted code (cpt 62321). In not sustaining a fee schedule defense, Master Arbitrator Trestman noted in pertinent part:

*".... Per NJAC 11:3-29.4[e], the NJ PIP fee schedule requires providers to submit their billing utilizing the most recent AMA CPT codes.... **CPT code 62321 (was) the AMA replacement code for CPT code 62310** included in the NJ Fee schedule and lists the corresponding fees NJ fee schedule has not been amended since the AMA designated code change. **Per NJAC 11:3-29.4[e], when a CPT code for the service performed has been changed since the latest published fee schedule, the provider is required to bill the actual and correct code found in the most recent version of the AMA's coding....** remanding this case back to the lower arbitrator...." (emphasis added)*

On remand (AAA# 17-18-1103-7037), Arbitrator Malone noted in pertinent part:

*".... CPT code 62321 is not listed in the New Jersey fee schedule and there is no listing in the ASC fee section for CPT codes 72275 or 77003. [N.J.A.C. 11:3-29.4(e)]: **Codes in the Fee Schedule that do not have an amount in the ASC facility fee column are not reimbursable if performed in an ASC** (discussion of *New Jersey Manufacturers and Master Award*) **11 NYCRR 68.6 should be considered in determining the appropriate reimbursement amount for the services at issue**" (emphasis added)*

Herein, I observe cpt 62323 was adopted by the AMA, replacing cpt 62311, and that it was *crosswalked* prior to the DOS.

Upon review, I find that as the NJFS does not provide for reimbursement to an ASC under cpt 72275, reimbursement for same is denied. NJCA 11:3-29.5(a).

With respect to cpt 62323, upon considerable review, including of awards of colleagues and other Master Arbitrators that addressed the impact of the ruling in *New Jersey Manufacturers*, *supra*, I deem a code *crosswalking* to be appropriate. As the subject procedure occurred in the New Jersey North region, while cpt 62311 would be

ordinarily billed by an ASC at a sum greater (\$1,012.32) than that billed (as amended), respondent has not provided a comparative analysis as to what cpt 62311 would be billed pursuant to the NJFS/New York EAPG.

Moreover, the uploaded submission was not consistent with respondent's position presented at the hearing. The burden of asserting a defense that applicant billed in excess of the fee schedule remains on respondent [East Coast Acupuncture, P.C. v. Hereford Ins. Co., 51 Misc. 3d 441 (Civ. Ct. 2016)], which would be especially of concern, where the application of the 33rd Amendment was required, and a comparative analysis of the respective fee schedules was necessary and not presented. As I find respondent's fee schedule defense was not cogent and singularly specific, the defense is not sustained. Robert Physical Therapy, *supra*; Continental Medical, *supra*.

Lastly, I note the amended sum is less than that initially billed for cpt 62323.

Conclusion

Applicant is awarded the amended sum of \$762.53, commencing 30 days after 11/29/18, when the claim was submitted to the insurer, as a denial had not been issued, and ending with the date of payment of the award. Belt Parkway Imaging, P.C. v. State Wide Ins. Co., 2010 N.Y. Slip Op. 52229(U)(App. Term 2010), citing Hempstead General Hospital v. Ins. Co. of North America, 208 A.D. 2d 501 (2nd Dept., 1994)[*where insurer fails to establish that it ever sent a denial of claim form to the provider, accrual of interest was never tolled*].

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	Amount Amended	Status
	Citimed Services, PA	10/31/18 - 10/31/18	\$1,452.18	\$762.53	Awarded: \$762.53
Total			\$1,452.18		Awarded: \$762.53

- B. The insurer shall also compute and pay the applicant interest set forth below. 03/23/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Simple interest on the above awarded amount shall be computed and paid at a rate of 2% per month, commencing 30 days after 11/29/18, when the claim was submitted to the insurer, as a denial had not been issued, and ending with the date of payment of the award. *Belt Parkway Imaging, P.C. v. State Wide Ins. Co.*, 2010 N.Y. Slip Op. 52229(U)(App. Term 2010), citing *Hempstead General Hospital v. Ins. Co. of North America*, 208 A.D. 2d 501 (2nd Dept., 1994)[*where insurer fails to establish that it ever sent a denial of claim form to the provider, accrual of interest was never tolled*].

C. Attorney's Fees

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

Respondent shall pay the applicant an attorney's fee, in accordance with 11 NYCRR 65-4.6.

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

02/23/2021
(Dated)

Gerry Wendrovsky

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:
2bf966498622ff8477b29a62c32e1751

Electronically Signed

Your name: Gerry Wendrovsky
Signed on: 02/23/2021