

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Dongkyun Kim DDS (Applicant)	AAA Case No.	17-20-1174-8242
- and -	Applicant's File No.	A20776
	Insurer's Claim File No.	0402116057 2EM
Allstate Fire & Casualty Insurance Company (Respondent)	NAIC No.	29688

ARBITRATION AWARD

I, Heidi Obiajulu, 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 03/05/2021
Declared closed by the arbitrator on 03/05/2021

Ashley Andrews-Santillo, Esq. from Munawar & Hashmat LLP participated in person for the Applicant

Judith Formica, Esq. from Law Offices Of Karen L. Lawrence participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 10,467.97**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant amended its claim to \$6577.73 because it solely seeks the reimbursement of the dental service [D9950] performed on 01/25/16, the E/M visit on 02/29/16, the dental services performed on 03/09/16, and the dental services performed on 03/16/16. It withdrew the remainder of its claim.

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

3. Summary of Issues in Dispute

Applicant seeks reimbursement of charges for the occlusal analysis- mounted case [CDT D9950] performed on 01/25/16, evaluation and management service [CPT code 99212]

performed on 02/29/16, therapy [CDT code 97530], a re-evaluation [CPT code 99212], local anesthesia [D9215], occlusal analysis-mounted case [D9950], Botox injections [CDT code J0586- 5 times], and Triamcinolone Acetonide/Kenalog [CDT/CPT code J3301] performed on 03/09/16, and Transcutaneous electrical stimulation [CPT code 64550], biofeedback modality [CPT code 90901], physical medicine modality [CPT code 97032], the evaluation and management service [CPT code 99212], local anesthesia [CDT code D9215], occlusal adjustment-limited [CDT code D9951], antibiotic oral irrigation [CDT code 09330], and root canal therapy-molar [CDT code D3330] performed on 03/16/16, following a motor vehicle accident occurring on 01/21/16. Respondent timely denied claim(s) for the occlusal analysis- mounted case [CDT D9950] performed on 01/25/16 and the evaluation and management service performed on 02/29/16 based upon fee schedule defenses and denied receiving copies of the applicant's claim forms for the dental services performed on 03/09/16 and 03/16/16.

4. Findings, Conclusions, and Basis Therefor

The below decision is based on the documents contained in the Modria ADR Electronic Case folder maintained by the American Arbitration Association (hereinafter referred to as AAA) as of the date of this hearing.

The applicant, as assignee of the Injured Party, seeks the reimbursement, with interest and counsel fees, under the No-Fault Regulations, for the occlusal analysis- mounted case [CDT D9950] performed on 01/25/16, the evaluation and management service [CPT code 99212] performed on 02/29/16, therapy [CDT code 97530], a re-evaluation [CPT code 99212], local anesthesia [D9215], occlusal analysis-mounted case [D9950], Botox injections [CDT code J0586- 5 times], and Triamcinolone Acetonide/Kenalog [CDT/CPT code J3301] performed on 03/09/16, and Transcutaneous electrical stimulation [CPT code 64550], biofeedback modality [CPT code 90901], physical medicine modality [CPT code 97032], the evaluation and management service [CPT code 99212], local anesthesia [CDT code D9215], occlusal adjustment-limited [CDT code D9951], antibiotic oral irrigation [CDT code 09330], and root canal therapy-molar [CDT code D3330] performed on 03/16/16, in the amended aggregate amount of \$6577.73.

This case arises out of a motor vehicle accident occurring on January 21, 2016, in which the Injured Party (YNK), a then 42-year-old female sustained multiple injuries including to her head, jaw, face, chest, neck, back, shoulder, hand, and knee when she was hit by the insured vehicle while walking as a pedestrian. As a result of the accident, she lost consciousness. After the accident, she was taken to the emergency department of North-Shore-Long Island Jewish Health System NSUH. She underwent CT scans of the chest, head, brain, and cervical spine. Thereafter, she was discharged.

On or about 01/25/16, the applicant initially evaluated the Injured Party and reported that she presented with TMJ pain of limited jaw opening and muscle fatigue, vertigo, nausea, sharp and dull headaches at temporal, frontal, parietal, and posterior skull region of the head. His physical examination revealed TMJ pain on the right [rated 6/10] and

left [7/10], right-clicking and popping on lateral palpation of the condyle, protrusive movement [3mm], class I occlusion, no evidence of oral cancer, neck nodes, oral lesions, or skin lesion. His diagnoses were disc dislocation with reduction, TMJ inflammation, and myofascial pain. Based on his review of the X-rays and exam, he noted tooth mobility at teeth #2, 13, 24, and 30 and a wire splint on teeth #22-27 for stabilization. He recommended an orthotic guard, biofeedback, therapeutic modalities, micro-current electrotherapy [alpha stim], transcutaneous electrical nerve stimulator, and Botox injections [Botulinum toxin].

Thereafter, the applicant submitted its claim form to the respondent seeking the reimbursement of the above dental services. The respondent partially reimbursed the applicant for all dental services except for the occlusal analysis-mounted case, billed under CDT code D9950. The applicant solely seeks the reimbursement of CDT code D9950. The respondent denied reimbursement on the grounds that: *"No diagnosis or ICD code was submitted with this bill."* However, it is well-settled that an insurer is instructed to send an applicant a verification request if additional information is needed to reimburse the claim. The respondent failed to submit evidence to show that it sent the applicant a verification request seeking a diagnosis or ICD code. I find that denying the claim was improper and unreasonable. Consequently, I find that the respondent failed to establish his defense. **Accordingly, for the above reasons, I find in favor of the applicant in the amount of \$250.00 regarding the date of service 01/25/16.**

The applicant performed dental re-evaluations and services on 02/01/16, 02/17/16, and 02/22/16. The respondent partially reimbursed the applicant for those services and denied the balance of the applicant's charges on fee schedule grounds. The applicant withdrew that portion of its claim.

On 02/29/16, the applicant performed a re-evaluation and dental services. The respondent partially reimbursed all the dental services except for the re-evaluation. In its denial, the respondent asserted the defense: *"This procedure/service is considered to be part of the global surgical package which includes all normal follow-up care for the period indicated in the New York Workers' Compensation Medical Fee Schedule. (Surgical Ground Rule 1)."* The applicant's attorney argued that the respondent failed to submit sufficient evidence to establish its defense; she questioned the surgery referenced. A review of the evidence in the record reveals that the respondent did not submit any fee schedule opinion to support its argument or to identify the referenced "surgery." Consequently, I find that the respondent failed to establish its fee schedule defense. **Accordingly, for the above reasons, I find in favor of the applicant in the amount of \$50.00 for the E/M visit [reimbursed under CDT code D0170].**

On 03/09/16, the applicant performed therapy [CDT code 97530], a re-evaluation [CPT code 99212], local anesthesia [D9215], occlusal analysis-mounted case [D9950], Botox injections [CDT code J0586- 5 times], and Triamcinolone Acetonide/Kenalog [CDT J3301 billed twice].

On 03/16/16, the applicant performed transcutaneous electrical stimulation [CPT code 64550- twice], biofeedback [CPT code 90901], alpha stimulation [CPT code 97032], an office visit [billed under CPT code 99212], local anesthesia [D9215], occlusal adjustment-limited [D9951], and antibiotic oral irrigation [D9330- twice].

The respondent did not issue any denials or verification requests pertaining to dates of service 03/09/16 and 03/16/16; it denied receiving those claim forms.

The applicant's attorney contends that it submitted sufficient evidence to create a presumption of mailing of those claim forms based on the affirmation of Michael Kim.

The respondent insured the motor vehicle involved in the automobile accident. Under New York's Comprehensive Motor Vehicle Insurance Reparation Act (the "No-Fault Law"), New York Ins. Law §§ 5101 et seq., the respondent was obligated to reimburse the Injured Party (or its assignee) for all reasonable and necessary medical and dental expenses arising from the use and operation of the insured vehicle.

Reviewing the affirmation by Michael Kim, I find that it is legally insufficient to create a presumption of mailing to and receipt by the respondent because it lacks the discussion of the office practice and procedures that ensure that the bills were mailed. He discusses the office's standard office practice and procedure that ensures that the bill was properly addressed; however, he does not discuss the procedure that ensures the mailing other than his statement set forth in paragraph 5 of his affirmation, where he stated: "*Once the bill has been created, the bill is placed in an envelope that is addressed to the insurance carrier and deposited into a USPS mailbox.*" There is no mention of the employee that takes the bill and places it in a USPS mailbox. He did not indicate that he mailed the bills or who is responsible for the actual mailing of the bills. Instead, he states that he reviewed the Injured Party's file and the attached submitted log that indicates the bill for date of service 03/09/16 was mailed on 03/14/16 and the bill for date of service 03/16/16 was mailed on 03/14/16. For those reasons, I find that the applicant failed to create a presumption of mailing of the bills with the affirmation by Michael Kim and attached log. Compare the cases Progressive Cas. Ins. Co. v. Metro Psychological Servs., PC 139 A.D.3d 693, (N.Y.A.D., 2nd Dept., May 04, 2016) and New Chiropractic Care, PC v. Nationwide Ins. Co. of N.Y. 67 Misc. 3d 1226 (A), (N.Y. City Civ. Ct., June 01, 2020). It is also curious that the applicant submitted mail manifests with the USPS postmark regarding other dates of service, which is actual proof of mailing. No such evidence of actual mailing for dates of service 03/09/16 and 03/16/16 was submitted [which would have been okay had Michael Kim's affirmation been legally sufficient]. Therefore, I find that the portion of the applicant's claim seeking the reimbursement of the dental services performed on 03/09/16 and 03/16/16 is dismissed without prejudice based on the applicant's failure to demonstrate that the claim was due and owing.

ACCORDINGLY, FOR THE ABOVE REASONS, I FIND IN FAVOR OF THE APPLICANT IN THE AGGREGATE AMOUNT OF \$300.00.

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
	Dongkyun Kim DDS	01/25/16 - 01/25/16	\$376.49	\$250.00	Awarded: \$250.00
	Dongkyun Kim DDS	02/01/16 - 02/01/16	\$1,830.49	\$0.00	Withdrawn with prejudice
	Dongkyun Kim DDS	02/17/16 - 02/17/16	\$189.78	\$0.00	Withdrawn with prejudice
	Dongkyun Kim DDS	02/22/16 - 02/22/16	\$99.78	\$0.00	Withdrawn with prejudice
	Dongkyun Kim DDS	02/29/16 - 02/29/16	\$255.71	\$50.22	Awarded: \$50.00
	Dongkyun Kim DDS	03/09/16 - 03/09/16	\$4,250.00	\$4,174.25	Dismissed without prejudice
					Dismissed

	Dongkyun Kim DDS	03/16/16 - 03/16/16	\$2,475.00	\$2,103.26	without prejudice
	Dongkyun Kim DDS	03/23/16 - 03/23/16	\$205.49	\$0.00	Withdrawn with prejudice
	Dongkyun Kim DDS	03/30/16 - 03/30/16	\$205.79	\$0.00	Withdrawn with prejudice
	Dongkyun Kim DDS	05/25/16 - 05/25/16	\$300.05	\$0.00	Withdrawn with prejudice
	Dongkyun Kim DDS	06/08/16 - 06/08/16	\$279.39	\$0.00	Withdrawn with prejudice
Total			\$10,467.97		Awarded: \$300.00

- B. The insurer shall also compute and pay the applicant interest set forth below. 08/11/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant's award in the amount of \$300.00 shall bear interest at a rate of two percent per month, calculated on a pro-rata basis using a 30-day month from 08/11/20, the date that the applicant initiated this arbitration, to the date of the payment of the award.

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 New York

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

03/10/2021
(Dated)

Heidi Obiajulu

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:
733b74c104d8cd3552a712c2a58551de

Electronically Signed

Your name: Heidi Obiajulu
Signed on: 03/10/2021