

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Hank Ross Medical PC
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-20-1156-8744
Applicant's File No.	3095373
Insurer's Claim File No.	0296514160101040
NAIC No.	35882

ARBITRATION AWARD

I, Keith Tola, 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 08/02/2021
Declared closed by the arbitrator on 08/02/2021

Elvira Messina, Esq. from Law Offices of Andrew J. Costella Jr., Esq. participated in person for the **Applicant**

Robert Sheridan, Esq. from Geico Insurance Company participated in person for the **Respondent**

2. The amount claimed in the Arbitration Request, **\$ 7,735.57**, 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

This case stems from a New York motor vehicle accident which occurred on September 11, 2019, wherein the EIP allegedly sustained injuries.

Applicant seeks compensation for an office visit on November 5, 2019. Respondent denied based on the "45 Day Rule."

Applicant also seeks compensation of its fee for the shoulder surgery performed on November 18, 2019. Respondent denied for lack of medical necessity, based on the January 3, 2020 Peer Review of Howard Kiernan, M.D. Alternatively, respondent set forth a fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

This Award was issued upon consideration of the parties' arguments and upon review of the relevant evidence contained within the ADR Center files.

Issue #1: MEDICAL NECESSITY FOR SURGERY

Peer Review - Dr. Kiernan

Dr. Kiernan confirmed that the EIP was examined by Dr. Richard Seldes on October 10, 2019, and that the positive clinical findings at that time included left shoulder limitations of range of motion, positive Hawkins sign, a positive impingement sign, a positive O'Brien's test and tenderness to palpation at the posterior aspect of the left shoulder. Physical therapy was prescribed and left shoulder MRI was ordered. He also acknowledged the EIP the MRI, which was performed on October 17, 2019, revealed evidence consistent with a humeral/SLAP tear. Dr. Kiernan also confirmed that the EIP was examined by Dr. Ross on November 5, 2019, and that positive clinical findings included tenderness in the lateral acromion, a positive impingement sign, positive Speed's and Yergason's test, reproductive clicking, and decreased range of motion.

Despite the positive clinical and diagnostic findings mentioned above, Dr. Kiernan concluded the left surgery arthroscopic surgery was not medically necessary. He indicated, in pertinent part:

"... On review of the physical therapy records, the claimant only had 19 sessions of therapeutic exercises for the left shoulder prior to proceeding with surgical intervention. This is an inadequate trial of conservative care to determine that conservative treatment was ineffective, at which point surgery would be considered."

Dr. Kiernan cited the Office Disability Guidelines for the proposition at least 3 months of conservative treatment, including physical therapy, should be attempted before indicating surgery for SLAP lesions. Three months is adequate if the care has been continuous and six months if it has been intermittent. He noted the EIP only had 19 sessions of physical therapy prior to the surgery, which is about six weeks' worth of treatment, not three month's worth.

Respondent's Burden

Based on the opinions of Dr. Kiernan, respondent satisfied its burden. The presumption of medical necessity is removed and the burden shifts to applicant, to prove medical necessity for this surgery by a fair preponderance of the evidence.

Applicant's Evidence

Applicant submitted the Rebuttal of the EIP's surgeon, Hank Ross, M.D. Dr. Ross indicated that conservative care is not a prerequisite prior to conducting surgery. He also noted the Official Disability Guidelines relied upon by Dr. Kiernan is neither authoritative nor reflective of proper and recognized standards of orthopedic care. In any event, Dr. Ross confirmed the EIP did receive physical therapy and acupuncture prior to surgery, and also took anti-inflammatory pain medications - all of which did not provide the EIP with relief. Dr. Ross noted that under the circumstances the surgery was recommended in lieu of conservative care. Noting the clinical findings as reported on the examination reports discussed hereinabove, Dr. Ross indicated the EIP presented with significant positive objective clinical examination and MRI test findings. His impression upon examining the EIP was that of traumatic left shoulder SLAP tear and partial rotator cuff tear which had not improved with conservative measures. "Thus, pursuant to my detailed orthopedic examination and properly accepted medical practice, I advised my patient that in light of his refractory nature with conservative measures, positive clinical and MRI test findings and medical history, he would benefit from arthroscopic left shoulder surgery."

Dr. Ross reiterated his position that the proper standard of care does NOT mandate conservative care with the specific type of shoulder injuries sustained by the EIP.

Determination

Giving the overwhelming documented positive clinical and diagnostic findings to confirm a possible tear, I am persuaded by Dr. Ross insofar as I find the surgery was consistent with the EIP's condition and circumstances and in the EIP's best interest. I also note that the Official Disability Guidelines were not adopted as binding authority, and while perhaps offering some persuasive guidance they are but a cost-benefit analysis rather than medical standards. I find applicant has proven medical necessity for the surgery by a fair preponderance of the evidence, as required.

This claim is granted subject to respondent's fee schedule defense.

FEE SCHEDULE

Applicant billed a total of \$7498.63 for the surgery, according to the following breakdown:

Code 29826 - \$451.20;

Code 29807 = \$2489.66;

Code 29823 = \$1878.13;

Code 29999 = \$900.00; and

Code 29821 = \$1779.64.

Respondent provided the Fee Schedule report of Carolyn Mallory, CPC. Ms. Mallory provided the following calculations:

Code 29807: $10.87 \text{ RVU} \times 229.04 \text{ CF} = \2489.66

Code 29823: $\text{RVU } 8.20 \times 229.04 \text{ CF} = \$1878.13 \times 50\% \text{ per Surgery Ground Rule \#5 (multiple procedure reduction)} = \939.07

Code 29826: $\text{RVU } 1.97 \times 229.04 \text{ CF} = \451.21 (provider only charged \$451.20)

Ms. Mallory indicated no reimbursement is warranted under Code 29821. She noted, in relevant part: "According to the American Medical Association and the AAOS, to report 29821, the "entire intra-articular synovium" must be removed. The AAOS instructs that 29821 should only be used when the underlying diagnosis is pathologic synovium such as is found in rheumatoid arthritis or pigmented villonodular synovitis. There is no mention of either of these diagnosis codes in the medical records." Ms. Mallory also noted that 29821 is inclusive to more extensive procedures

Ms. Mallory indicated no reimbursement is warranted under Code 29999 as well. She indicated there is nothing in the operative report that has not already been billed that would suggest that CPT 29999 would be submitted.

In summary, Ms. Mallory recommended reimbursement of \$3879.93.

I find Ms. Mallory provided a well reasoned fee schedule analysis. I note, applicant has failed to provide evidence to the contrary.

In view of the foregoing, applicant is hereby awarded \$3879.93.

Issue #2: OFFICE VISIT - "45 Day Rule"

The office visit at issue was conducted on November 5, 2019. Respondent denied based on the "45 Day Rule." Applicant has come forward with proof of mailing, however its proof confirms mailing on December 26, 2019. However, the 45th day after the date of service was December 20, 2019. As such, applicant has provided proof of untimely mailing. Consequently, this portion of applicant's claim is denied.

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
	Hank Ross Medical PC	11/05/19 - 11/18/19	\$7,735.57	Awarded: \$3,879.93
Total			\$7,735.57	Awarded: \$3,879.93

- B. The insurer shall also compute and pay the applicant interest set forth below. 02/14/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant commenced arbitration by filing on 2/14/20. Applicant filed beyond 30 days of receipt of the denial. As such, Respondent shall pay the applicant interest computed from the date of filing, 2/14/20, at the rate of 2% per month, simple, and ending with the date of payment of the award subject to the provisions of 11 NYCRR § 65-3.9(e).

C. Attorney's Fees

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

The insurer shall also pay the applicant for attorney's fees as set forth below Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. See, 11 NYCRR Section 65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR Section 65-4.5(e). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or the court, subject to a maximum fee of \$850.00" Id. The minimum attorney fee that shall be awarded is \$60.00. 11 NYCRR Section 65-4.5(c). However, if the

benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR Section 65-4.6(i). For claims that fall under the Sixth Amendment to the regulation the following shall apply: "If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved disputes, subject to a maximum fee of \$1,360.00."

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

08/31/2021

(Dated)

Keith Tola

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:
1c4e49bfb148fb236d769369322f703b

Electronically Signed

Your name: Keith Tola
Signed on: 08/31/2021