

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Advanced Shoulder Knee Orthopedics
(Applicant)

- and -

Country-Wide Insurance Company
(Respondent)

AAA Case No. 17-20-1168-9242

Applicant's File No. 3097680

Insurer's Claim File No. 000347321 001

NAIC No. 10839

ARBITRATION AWARD

I, Eileen Casey, 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 08/12/2021
Declared closed by the arbitrator on 09/11/2021

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

Edilaine D'Arce, Esq. from Jaffe & Velazquez, LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 7,498.04**, was AMENDED and permitted by the arbitrator at the oral hearing.

The original amount claimed was \$7,498.04 for an office visit and sling provided on October 24, 2019, office visits on October 26, 2019, November 7, 2019, and November 16, 2019, and the physician fee associated with left shoulder arthroscopic surgery performed on November 22, 2019. Applicant's counsel withdrew the claims for the office visit and sling provided on October 24, 2019 and the office visit on November 16, 2019 based on proof of payment and amended the amount claimed to \$7,206.87 for the office visits on October 26, 2019 and November 7, 2019, and the physician fee associated with left shoulder arthroscopic surgery performed on November 22, 2019.

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

3. Summary of Issues in Dispute

The EIP (LYJ), a 63-year-old male, was involved in a motor vehicle accident on October 22, 2019. The amount claimed, as amended, is \$7,206.87 for office visits on October 26, 2019 and November 7, 2019 and the physician fee associated with left shoulder arthroscopic surgery performed on November 22, 2019. Respondent neither paid nor denied Applicant's claims for the office visits on October 26, 2019 and November 7, 2019 but instead requested additional verification. Respondent denied Applicant's claim for the physician fee associated with left shoulder arthroscopic surgery performed on November 22, 2019 based on a December 26, 2019 peer review by Dr. Julio Westerland, M.D. The issues are whether Respondent established that the request for arbitration as to the office visits is premature as there are outstanding requests for verification and whether Respondent established a defense of lack of medical necessity based on the peer review.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon oral arguments and a review of the documents contained in the ADR Center maintained by the American Arbitration Association. Post hearing submissions were permitted and considered. The original amount claimed was \$7,498.04 for an office visit and sling provided on October 24, 2019, office visits on October 26, 2019, November 7, 2019, and November 16, 2019, and the physician fee associated with left shoulder arthroscopic surgery performed on November 22, 2019. Applicant's counsel withdrew the claims for the office visit and sling provided on October 24, 2019 and the office visit on November 16, 2019 based on proof of payment and amended the amount claimed to \$7,206.87 for the office visits on October 26, 2019 and November 7, 2019, and the physician fee associated with left shoulder arthroscopic surgery performed on November 22, 2019.

Applicant's Prima Facie Case

The evidence demonstrates that the EIP (LYJ), a 63-year-old male, was involved in a motor vehicle accident on October 22, 2019.

Applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained and 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 was overdue. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find that Applicant established a prima facie case for reimbursement.

Requests for Additional Verification

Respondent neither paid nor denied Applicant's claims for the office visits on October 26, 2019 and November 7, 2019 but instead requested additional verification.

It is accepted that once presented, a claim for health care benefits must be paid or denied within (30) thirty days of an insurer's receipt thereof. This period may be tolled by requesting additional verification, as provided by 11 NYCRR Section 65-3.8 (a) (1). The insurer must make the verification request within fifteen (15) business days from its receipt of the claim, pursuant to 11 NYCRR Section 65-3.5. If a response to the initial request for additional verification is not received by the carrier within thirty (30) days, then, within ten (10) calendar days after the thirty-day period, the carrier must make a second request. See, 11 NYCRR Section 65 3.6. An insurer is not obligated to pay or deny a claim until it has received all relevant information.

The evidence demonstrated that the claims for the office visit on October 26, 2019 and November 7, 2019 were received by Respondent on November 20, 2019 and November 22, 2019 respectively. Respondent sent initial verification requests on December 10, 2019 and follow-up requests on January 10, 2020. The requests asked for progress notes (SOAP notes).

Applicant's counsel objected to the requests for verification which were submitted three (3) days before the hearing. I agreed to consider the verification requests, but the record was left open for three (3) weeks to allow Applicant to respond to the late submission.

Applicant submitted a post-hearing submission containing a December 31, 2019 letter from Andrew Costello, Esq. in response to the verification requests stating that the "Progress Notes (SOAP Notes)" do not exist. Respondent also submitted an affirmation of Mr. Costello stating that the response was mailed on December 31, 2019.

As long as a medical provider's documentation is arguably responsive to an insurer's verification request, the insurer must act within 30 days of the medical provider's response, or it will be precluded from presenting any noncoverage defenses; an insurer must affirmatively act once it receives a response to its verification request. *All Health Medical Care, P.C. v. Government Employees Ins. Co.*, 2 Misc.3d 907, 771 N.Y.S.2d 832 (Civ. Ct. Queens Co. 2004).

There is no provision in the No-Fault regulations which permit a claimant or an insurance company to ignore communications from each other without risking its chance to prevail in the matter. *Back to Back Chiropractor, P.C. v. State Farm Mutual Automobile Ins. Co.*, 35 Misc.3d 1241(A), 2012 N.Y. Slip Op. 51088(U) at 5, 2012 WL 2161476 (Dist. Ct. Suffolk Co., C. Stephen Hackeling, J., June 15, 2012).

The Peer Review (Lack of Medical Necessity) Defense

Lack of medical necessity is a defense to an action to recover no-fault benefits, which an insurer may assert upon a timely denial, based either on a medical examination or a peer review report. *Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp.*, 2003 N.Y. Slip Op. 50842(U), 2003 WL 21049583 (App. Term 2d & 11th Dists. 2003).

Respondent denied Applicant's claim for the physician fee associated with left shoulder arthroscopic surgery performed on November 22, 2019 based on a December 26, 2019 peer review by Dr. Julio Westerband, M.D.

In his report, Dr. Westerband listed the records he reviewed and detailed the EIP's pertinent medical history. Dr. Westerband said that on 11/07/2019, the EIP presented to Daniel J. Yoo, M.D. with complaints of pain in the left shoulder. The EIP was evaluated and was recommended conservative treatment. Subsequently, the left shoulder arthroscopy was performed on 11/22/2019. Dr. Westerband said that the left shoulder arthroscopy was not medically necessary. He explained that it was premature to consider operating on someone who had not been provided the correct non-surgical treatment. He wrote that, as per the medical records, the EIP received less than a month of physical therapy sessions when the surgery was recommended, which is inadequate to assess the benefit the EIP could have gained from conservative treatment. Dr. Westerband said that Dr. Yoo should have treated the EIP for a left shoulder sprain or for a partial thickness tear with pain and only if the EIP had failed to respond to adequate conservative treatment, including physical therapy for 3 to 6 months and judicious use of steroid injections, further evaluation, testing, and appropriate treatment should have been considered. Dr. Westerband also noted that the MRI study of the left shoulder revealed partial thickness tear of rotator cuff tendon and posterior labral tear. Dr. Westerband stated that the presence of a labral tear and rotator cuff tear on the MRI is not an absolute surgical indication. He explained that the symptoms caused due to such findings can be treated conservatively including physical therapy sessions and cortisone injections. He added that the records do not document any evidence of posttraumatic instability nor failure to respond to judicious use of intra articular steroids. He explained that surgery is usually indicated if the EIP's pain is not relieved by 3 to 6 months of nonoperative treatment, including activity modification - avoidance of overhead or pain-provoking actions - NSAID use, physical therapy, strengthening, and subacromial or glenohumeral steroid injections. He asserted that, in this case, conservative treatment was not adequate and shoulder arthroscopy was performed prematurely. Dr. Westerband opined that the left shoulder arthroscopic surgery, together with the associated anesthesia, were not medically necessary.

Respondent has timely raised and established lack medical necessity, the burden of proof then shifts to the Applicant to establish that the disputed services were reasonable and medically necessary. If the insurer medical examination or peer review is not rebutted, the insurer is entitled to denial of the claim. *A Khodadadi Radiology v. New York Central*, 16 Misc.3d 131(A), 841 N.Y.S.2d 824, 2007 N.Y. 51342(U), 2007 WL 1989432 (App. Term 2d & 11th Dists. 2007).

The courts have held that a peer review report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical

practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. See, *Nir v. Allstate Ins. Co.* 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005).

Rebuttal

Applicant submitted a June 7, 2021 rebuttal from Dr. Daniel Yoo, the EIP's surgeon. Dr. Yoo stated that Dr. Westerband failed to review his 11/16/19 re-exam report. Dr. Yoo noted that the surgery was recommended as a result of this re-exam. Dr. Yoo also questioned the authority to which Dr. Westerband cited. Dr. Yoo said that the proper standard of orthopedic care, as well as the NYS WCB Shoulder Injury Medical Treatment Guidelines, clearly recommend the type of shoulder surgery performed, in lieu of "conservative care", when a patient has the specific type of shoulder injuries that the EIP sustained as a result of his car collision. Dr. Yoo stated that the EIP had numerous positive objective clinical findings and orthopedic deficits as well as an MRI of the left shoulder significant for partial thickness tear of the rotator cuff and a labral tear. He added that conservative measures (such as pain medications and rest) had been attempted prior to the surgery without improvement. He added that the peer review doctor failed to recognize that "steroids" are not mandatory prior to performing the surgery. He added that the EIP's left shoulder condition had not improved and the EIP continued to demonstrate signs of worsening orthopedic deficits. Dr. Yoo said that he advised the EIP that in light of his refractory nature with conservative measures, positive exam, MRI findings, and medical history, he would benefit from arthroscopic shoulder surgery.

Medical Reports

Applicant also submitted various medical reports including Dr. Yoo's 11/16/19 report which noted the EIP's constant left shoulder pain rated 10/10. Examination of the left shoulder revealed positive impingement signs of Neer and Hawkins. Shoulder abduction greater than 90 degrees was painful. Speed's test was mildly positive. O'Brien's test was positive. Dr. Yoo wrote that the EIP had left shoulder impingement, partial thickness tear of the rotator cuff, and posterior labral tear. Cortisone injection was discussed but the EP wanted to avoid potential side effects. Left shoulder surgery was recommended.

Collateral Estoppel

I considered Dr. Westerband's peer review and Dr. Yoo's rebuttal in a linked case AAA # 17-20-1164-0356 (09/07/2021). That case was brought by Allied Board Certified Physicians to recover for the anesthesia associated with the left shoulder arthroscopic surgery performed on November 22, 2019. In that case, I found that that Dr. Yoo's rebuttal was sufficient to meet the Applicant's burden on the issue of medical necessity. I deferred to Dr. Yoo, the EIP's orthopedic surgeon, and found that surgery was medically necessary.

Collateral estoppel bars a party from litigating again in a subsequent action or proceeding an issue raised in a prior action or proceeding and decided against that party

or those in privity. See, *Buechel v. Bain*, 97 N.Y.2d. 295, 303 (2001). Two requirements must be met before collateral estoppel can be invoked: (1) There must be an identity of issue, which has necessarily been decided in the prior action and is decisive of the present action; and (2) there must have been a full and fair opportunity to contest the decision now said to be controlling. *Id.* at 303-304.

Fee Schedule Defense

Respondent also raised a fee schedule defense as to the left shoulder surgery.

11 NYCRR 65-3.8(g)(1), in effect as of April 1, 2013, provides that proof of the fact and amount of loss sustained pursuant to Insurance Law section 5106 (a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for such claimed medical services under any circumstances for those claimed medical service fees that exceed the charges permissible pursuant to Insurance Law sections 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers.

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, *Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co.*, 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006).

The services in dispute were provided to a New York resident and performed in New Jersey. Pursuant to 11 NYCRR 68.6, for services performed out of the State of New York for a resident of New York State the insurer shall reimburse the provider the lowest of the (1) the amount of the fee set forth in the region of this State that has the highest applicable amount in the fee schedule for that service (2) the amount charged by the provider; and (3) the prevailing fee in the geographic location of the provider.

Applicant billed \$7,049.82 (\$948.22 under CPT code 29805-59, 2,448.43 under CPT code 29826-59, \$1,878.12 under CPT code 29823-59, \$1,628.47 under CPT code 29820-59, and \$148.58 under CPT code 64418-59) or the physician fee related to the left shoulder surgery.

Respondent submitted a Support Claim Services fee audit. The fee audit states that the proper reimbursement for the physician fee under the New York Workers Compensation fee schedule is \$3,216.87 (\$0.00 under CPT code 29805-59, \$451.21 under CPT code 29826-59, \$1,878.12 under CPT code 29823-59, \$814.24 under CPT code 29820-59, and \$73.30 under CPT code 64418-59). The fee audit states that CPT code 29823-59 should be paid in full and CPT codes 29820-59 and 64418-59 should be paid at 50% pursuant to Surgical Ground Rule 5. It adds that CPT code 29805-59 is not separately payable. The fee audit further states that CPT code 29826-59 should be reimbursed at \$451.21 pursuant to the appropriate surgical fee schedule.

Respondent also submitted a fee coder affidavit from Jennifer Budden, CPC She stated that the proper reimbursement for the physician fee under the New York Workers Compensation fee schedule is \$3,216.87.

Applicant did not submit the affidavit or other evidence from a fee coding professional.

Findings

Based on the foregoing, as to Applicant's claims for office visits on October 26, 2019 and November 7, 2019, I find that the evidence established that Applicant responded to Respondent's requests for verification on December 31, 2019. The January 10, 2020 follow-up requests did not address the response and there was no evidence submitted to show that Respondent took further action within 30 days of Applicant's response. Therefore, I find that the claims are overdue and Applicant is entitled to reimbursement for these office visits.

As to Applicant's claim for the physician fee associated with left shoulder arthroscopic surgery performed on November 22, 2019, I find that it has already been determined, in a linked case AAA # 17-20-1164-0356, that the surgery was medical necessary and Respondent is collaterally estopped from relitigating the issue. Additionally, I again I defer to Dr. Yoo, the EIP's orthopedic surgeon, and find that surgery was medically necessary. However, I find that Respondent's evidence established that the proper reimbursement for the physician fee is \$3,216.87. Applicant submitted no evidence in rebuttal to fee audit and fee coder affidavit.

Accordingly, Applicant is awarded \$3,373.92 (\$64.07 for the office visit on October 26, 2019; \$92.98 for the office visit on November 7, 2019, and \$3,216.87 for the physician fee for the left shoulder surgery

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
	Advanced Shoulder Knee Orthopedics	10/24/19 - 11/22/19	\$7,498.04	\$7,206.87	Awarded: \$3,373.92
Total			\$7,498.04		Awarded: \$3,373.92

B. The insurer shall also compute and pay the applicant interest set forth below. 06/19/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Since the claim(s) in question arose from an accident that occurred on or after April 5, 2002, the insurer shall compute and pay the applicant the amount of interest computed from the above date, which is the date that arbitration was requested, 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 (c).

C. Attorney's Fees

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

Respondent shall pay Applicant an attorney's fee, in accordance with 11 NYCRR § 65-4.6(d). Therefore, the insurer shall pay the applicant an attorney's fee of 20% of benefits plus interest, with no minimum fee and a maximum fee of \$1,360. 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 65-4.6(b).

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

09/29/2021

(Dated)

Eileen Casey

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:
477d9f85ebc62ce66748b1a39283cde4

Electronically Signed

Your name: Eileen Casey
Signed on: 09/29/2021