

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Eastern Medical Practice PC
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-19-1151-3998
Applicant's File No.	JL19-104149
Insurer's Claim File No.	0554136210101054
NAIC No.	22055

ARBITRATION AWARD

I, Antonietta Russo, 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: Assignor

1. Hearing(s) held on 09/02/2021
Declared closed by the arbitrator on 09/02/2021

Robert Bott from The Licatesi Law Group, LLP participated in person for the Applicant

Mark Graziano from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,837.92**, was AMENDED and permitted by the arbitrator at the oral hearing.

At the hearing, Applicant amended the claim amount to \$1,283.44.

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

3. Summary of Issues in Dispute

The Assignor, a 43-year-old male front-seated passenger, was reportedly involved in a motor vehicle accident on August 16, 2019. Following the accident, Assignor suffered injuries which resulted in him seeking medical treatment. Thereafter, a treatment plan was recommended and the Assignor underwent an office evaluation, trigger point injections with guidance, and outcome assessment testing on September 30, 2019. Applicant is seeking

reimbursement for these services; however, the claims were timely denied based on the peer review of Dr. Jackson and the issues presented at the hearing were:

- 1.) Whether Respondent can sustain its lack of medical necessity defense predicted on the peer review report?
- 2.) Whether the Applicant billed in excess of the fee schedule?

4. Findings, Conclusions, and Basis Therefor

The Applicant and the Respondent submitted documentary evidence in support of their respective positions. All such evidence is contained within MODRIA maintained by the American Arbitration Association, as of the date of the hearing. The below-noted decision is based upon my review of the submitted evidence, along with the oral argument of the representatives present at the hearing.

On September 2, 2021, this case was heard by the undersigned in conjunction with several linked cases on the same hearing date. All the matters involved the same Assignor, date of accident and the services were all denied based on the peer reviews by Dr. Harry Jackson. Thus, all evidence was considered collectively and heard in tandem. Consequently, after reviewing the evidence included on the ADR Center for these matters, I conclude the same decision regarding medical necessity is appropriate for each hearing.

I find that Applicant has demonstrated its prima facie case for the claim in dispute. A medical provider establishes prima facie showing of their entitlement to judgment as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms 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); See also: Viviane Etienne Med. Care v Country-Wide Ins. Co. 2015 NY Slip Op 04787 (proof of mailing is satisfied by an insurer's admission of receipt of bills.) Similarly, I find that the Respondent has proffered a timely denial which preserves the defense of lack of medical necessity and fee schedule. As the defense of fee schedule may be raised at any time under the revised regulations, it is not material to the defense whether the denial is timely. See, 11 NYCRR §65-3.8(g)(1)(ii); see also, Precious Acupuncture Care, P.C. v Hereford Ins. Co., 2018 NY Slip Op 50042(U), 58 Misc. 3d 147(A) (Appellate Term, Second Dept. 2018).

MEDICAL NECESSITY

Once Applicant has established a prima facie case, the burden is on the insurer to prove that the medical treatment was not medically necessary. 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 Dep't. 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).

In order to support a lack of medical necessity defense respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See, *Provvedere, Inc. v. Republic Western Ins. Co.*, 2014 NY Slip Op 50219(U) (App. Term 2nd, 11th and 13th Jud. Dists. 20140. Respondent bears the burden of production in support of its lack of medical necessity defense, which if established shifts the burden of persuasion to applicant. See generally, *Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006). The Appellate Courts have not clearly defined what satisfies this standard except to the extent that "bald assertions" are insufficient. *Amherst Medical Supply, LLC v. A Central Ins. Co.*, 2013 NY Slip Op 51800(U) (App. Term 1st Dept. 2013). However, there are myriad civil court decisions tackling the issue of what constitutes a "factual basis and medical rationale" sufficient to establish a lack of medical necessity.

The civil courts have held that a defendant's peer review or medical evidence must set forth more than just a basic recitation of the expert's opinion. The trial 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 generally, *Nir v. Allstate*, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005); See also, *All Boro Psychological Servs. P.C. v. GEICO*, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012). "Generally accepted practice is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." *Nir, supra*.

In support of its' contentions that the services were not medically necessary, Respondent relied upon the peer review report prepared by Harry E. Jackson, MD. dated November 19, 2019. In Dr. Jackson's report, he chronicles the Assignor's medical records and concludes the services were not medically necessary. He references the exam by Dr. Kopach, PA and asserts the submitted records show that the claimant had a soft tissue injury and the standard of care is physical therapy and analgesics for 6-12 weeks. Trigger point injection with methylprednisolone is not medically indicated - this treatment is palliative and not therapeutic. Also, there is no justification provided for TPIs. He further states, it is unclear from the medical documentation, what if any other conservative therapies, such as NSAIDs were tried and what was the response of the claimant to these oral medications and PT. In terms of the outcome assessment testing, there is no information that indicates this testing added

anything to the claimant's therapy or care and it does not appear that the claimant benefited from this study in any way. Formal outcome assessment testing does not provide useful clinical information that cannot be obtained by standard clinical examination in this clinical setting. Based on Dr. Jackson's opinions, Respondent denied the claim and disallowed payment.

I find that Dr. Jackson's peer review set forth a clear factual basis and medical rationale to recommend against reimbursement for the services at issue. Dr. Jackson's peer review advanced reasonable arguments in support of the position that the services were unnecessary. The burden returns to Applicant to rebut Respondent's showing.

In response to Respondent's arguments, Applicant relied on their medical records, in addition to the rebuttal by Dr. Jonathan Landow, MD, a non-treating physician. The record indicates the assignor was evaluated and treated for his injuries by Tranquility Physical Therapy & Acupuncture PLLC, Rebound Acupuncture PC, Glenn H. Whitney, DC, Seo Han, MD, Simeon Isaacs DPM. All evaluations reports indicate the claimant had complaints of headache, neck pain radiating to the right upper extremity, low back pain radiating to the right lower extremity, mid back pain radiating to the back, right knee pain radiating to the right leg, right hip pain, right ankle pain radiating to the right leg and right foot, right shoulder pain, right elbow pain and right wrist pain radiating to the right upper arm and right forearm. The pain was at a level of 9-10/10. The physical examination of the claimant revealed decreased ROMs; tenderness; muscle spasm; sprain/strain; decreased DTR; sensation light touch to pinprick; hyperesthesia; decreased muscle strength; and Qi and blood stagnation. The claimant also had positive orthopedic testing including Percussion test, Soto Hall test, Foraminal Compression test, Jackson Compression test, Cervical Distraction test, Shoulder Depression test, Kemp's test, Valsalva test, SLR test, Milgram's, Fabere-Patrick test, Ely's test, Bechterew's test and Impingement sign. Dr. Landow notes the Assignor's findings and states TPIs are used not only to treat myofascial pain syndromes, but also to treat a wide variety of pain syndromes and other painful conditions. Dr. Landow also references the MRI findings of the cervical and lumbar spine; right shoulder, right knee, right wrist and right ankle. Based on the exam and MRI findings, Dr. Landow asserts the Assignor's injuries were not soft tissue injuries. In terms of the outcome assessment, he stated the goal of the testing is to provide a more comprehensive analysis of the symptoms exhibited, in order to formulate a more specific treatment plan. Validated outcome measures are critical to the evaluation process. The outcome assessment testing was necessary to get an objective determination of the claimant's functional impairment and limitations and to note the progress made and to decide the future treatment plan.

In this matter, I am faced with conflicting opinions concerning the medical necessity for the disputed treatment herein. There are no legal issues to resolve. This dispute involves solely an issue of fact, that is, whether or not the treatment was medically necessary. Resolution of that fact is determined by which opinion is accepted by the trier of fact.

After carefully reviewing the reports, documents and opinions for each side, I find that the Applicant has met its burden and established the medical necessity for the services in question. The reports of the treating physicians, in addition to the rebuttal are found to be sufficiently comprehensive, and therefore, I am persuaded that the evidence collectively refutes Respondent's defense.

FEE SCHEDULE

Subsequently, Respondent has also questioned the fee schedule of the services in dispute and contends the proper reimbursable amount of the claim should be \$586.42. Applicant maintains the amended claim amount is correct.

An insurance carrier's timely asserted defense that the bills submitted were not properly No-Fault rated or that the fees charged were in excess of the Workers' Compensation fee schedule is sufficient, if proven, to justify a reduction in payment or denial of a claim. See New York Hosp. Med. Ctr. of Queens v. Country-Wide Ins. Co., 295 A.D.2d 583, 586 (2002); East Coast Acupuncture, P.C. v. New York Cent. Mut. Ins., 2008 NY Slip Op 50344(U) (App. Term 2d Dep't., Feb. 21, 2008); A.B. Med. Servs., PLLC v. American Tr. Ins. Co., 15 Misc.3d 132(A), 2007 NY Slip Op 50680(U) (App. Term, 2nd & 11th Jud Dists. 2007); Rigid Medical of Flatbush, P.C. v. New York Cent. Mut. Fire Ins. Co., 11 Misc.3d 139(A), 816 N.Y.S.2d 700, 2006 NY Op 50582 (U) (App. Term 2nd & 11th Jud Dists. 2006); Ultra Diagnostics Imaging v. Liberty Mut. Ins. Co., 9 Misc.3d 97, 98, 804 N.Y.S.2d 532, 2005 N.Y. Slip Op. 25402 (App Term, 2d Dep't.); Capio Med., P.C. v Progressive Cas. Ins. Co., 7 Misc 3d 129[A], 2005 NY Slip Op 50526 (U) (2005); Triboro Chiropractic & Acupuncture, PLLC v New York Cent. Mut. Fire Ins. Co., 6 Misc.3d 132 (A), 2005 NY Slip Op 50110 (U) (App Term, 2nd & 11th Jud Dists 2005).

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). See also, Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co., 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't., per curiam, 2006).

I am permitted to take judicial notice of the Worker's Compensation fee schedule. Kingsbrook Jewish Medical Center v. Allstate Insurance Company, 61 AD3d 13 (2d Dept. 2009); LVOV Acupuncture PC v. Geico Insurance Company,

32 Misc. 3d 144 (A) (App. Term 2d, 11th and 13th Jud. Dists. 2011). Natural Acupuncture Health PC v. Praetorian Insurance Company, 30 Misc. 3d 132 (A), 2011 N Y slip op 50040 (U), (App. Term 1st Dept. 2011).

In support of its fee schedule defense, Respondent relied upon a fee audit from Techsource which recommended reimbursement in the amount of \$586.42. No medical coder's signature or doctor's signature is affixed to the audit.

After a thorough review of the evidence and the supporting documents, I find that Respondent has not presented competent evidentiary proof that Applicant billed in excess of the appropriate fee schedule. I find Respondent's audit insufficient to sustain their burden as there is no identification within the Techsource document of the individual that performed the audit, any information surrounding that individual's qualifications, licensing, credentials, experience or training. As such, I find in favor of Applicant and award \$1283.44 for this claim.

Accordingly, I find in Applicant's favor and grant their amended claim.

Additionally, the parties discussed the possibility of the policy becoming exhausted and only a portion remains. Inasmuch as I find in favor of Applicant, the claim is awarded to the extent of the remaining balance of the policy.

Any further issues raised in the record are held to be moot and/or waived insofar as not raised at the time of the hearing. This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

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
	Eastern Medical Practice PC	09/30/19 - 09/30/19	\$1,837.92	\$1,283.44	Awarded: \$1,283.44
Total			\$1,837.92		Awarded: \$1,283.44

B. The insurer shall also compute and pay the applicant interest set forth below. 12/10/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30-day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely. *LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co.*, 12 N.Y.3d 217 (2009).

C. Attorney's Fees

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. 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 newly promulgated 11 NYCRR 65-4.6(d)." This amendment takes into account that the maximum attorney fee has been raised from \$850.00 to \$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, Antonietta Russo, 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)

Antonietta Russo

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:
10856f74c6e111ba5d6cad800925911

Electronically Signed

Your name: Antonietta Russo
Signed on: 09/29/2021