

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Macintosh Medical, P.C.  
(Applicant)

- and -

Geico Insurance Company  
(Respondent)

AAA Case No.	17-20-1166-9116
Applicant's File No.	JL20-114107
Insurer's Claim File No.	0666788160000002
NAIC No.	35882

**ARBITRATION AWARD**

I, Shawn Kelleher, 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: NC

1. Hearing(s) held on 10/25/2021  
Declared closed by the arbitrator on 10/25/2021

Anthony Licatesi, Esq. from The Licatesi Law Group, LLP participated for the Applicant

Tara Pisciotto, Esq. from Geico Insurance Company participated for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 3,675.84**, 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

The Assignor, NC, a 32-year-old female, was involved in a motor vehicle accident on 10/20/19. At issue in this case is \$3,675.84 for an office visit, trigger point injections, and outcome assessment testing performed on 2/18/20 and 3/17/20. Respondent timely denied the claim based upon a negative IME of Dr. William J. Walsh performed on 1/8/20. The issue presented is whether the services following the IME were medically necessary and, if so, what is the proper reimbursement under the New York State Workers' Compensation fee schedule.

4. Findings, Conclusions, and Basis Therefor

This case was 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 reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

Applicant establishes its prima facie entitlement to reimbursement with proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue. See Insurance Law § 5106 a; Viviane Etienne Med. Care v. Country-Wide Ins. Co., 25 N.Y.3d 498, 501 (2015); Mary Immaculate Hosp. v. Allstate Ins. Co., 5 A.D. 3d 742, 774 N.Y.S. 2d 564 (2<sup>nd</sup> Dept., 2004). Once an Applicant has established its prima facie case, the burden shifts to the insurer to establish that it timely and properly denied the claims, and the basis of its denial.

Based upon a review of the parties' submissions, I find that Applicant established its prima facie entitlement to reimbursement. I also find that Respondent timely denied the subject bills.

When an insurer asserts that the medical service was medically unnecessary, the burden is on the insurer to establish that the subject service was medical unnecessary by competent evidence such as an independent medical examination or a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. See generally, Kings Medical Supply Inc. v. Country Wide Ins. Co., 5 Misc. 3d 767 (N.Y.C. Civ. Ct., 2004); Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc. 3d 128 (App. Term, 2<sup>nd</sup> Dept., 2003].

An IME report asserting that no further treatment is medically necessary must be supported by a sufficiently detailed factual basis and medical rationale, which includes mention of the applicable generally accepted medical/professional standards. Carle Place Chiropractic v. New York Central Mut. Fire Ins. Co., 19 Misc.3d 1139(A), 866 N.Y.S.2d 90 (Table), 2008 N.Y. Slip Op. 51065(U), 2008 WL 2228633 (Dist. Ct., Nassau Co., May 29, 2008, Andrew M. Engle, J.). An IME report must set forth a factual basis and medical rationale for the conclusion that further services are not medically necessary. See generally, Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A) (App. Term 2<sup>nd</sup> Dept., 2008). If the IME doctors establishes that further medical services are not necessary, it becomes incumbent on the applicant to rebut the IME review. See, AJS Chiropractic, P.C. v. Mercury Ins. Co., 22 Misc. 3d 133(A) (App. Term, 2<sup>nd</sup> Dept., 2009). Where the Respondent presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden then shifts to the Applicant which must then present its own evidence of medical necessity. Andrew Carothers, M.D., P.C. v. GEICO Indemnity Company, 2008 NY Slip Op 50456U, 18 Misc. 3d 1147A, 2008 N.Y. Misc. LEXIS 1121, West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co. 13 Misc.3d 131, 824 N.Y.S.2d 759, 2006 NY Slip Op51871(U) (Sup. Ct. App. T. 2d Dep't 2006)].

Dr. Walsh examined the claimant on 1/8/20. The claimant presented with neck and low back pain. The examination revealed:

Cervical spine: Tenderness - negative. Muscle spasm - negative. Scars - negative. Deformity - negative. Range of motion: Flexion 0 to 50 degrees (50 normal). Extension 0 to 60 degrees (60 normal). Right lateral flexion 0 to 45 degrees (45 normal). Left lateral flexion 0 to 45 degrees (45 normal). Right rotation 0 to 80 degrees (80 normal). Left rotation 0 to 80 degrees (80 normal). There is no pain on cervical motion. There is no pain on cervical distraction or compression.

Neurologic: There is no loss of sensation to light touch in the upper extremities. There is no muscle atrophy or weakness. There is good grasp in both hands. Deep tendon reflexes in the upper extremities are normal and symmetrical.

Lumbar Spine: Tenderness - negative. Muscle spasm - negative. Scars - negative. Deformity - negative. Range of motion: Flexion 0 to 60 degrees (60 normal). Extension 0 to 25 degrees (25 normal). Lateral bending 25 degrees right, 25 degrees left (25 normal). Straight leg raising is negative bilaterally.

Neurologic: Deep tendon reflexes in the lower extremities are normal and symmetrical. There is no loss of sensation to light touch in the lower extremities. There is no muscle atrophy or weakness. The claimant is able to stand on tiptoes and heels.

The claimant was diagnosed with resolved cervical and lumbar spine strains.

Where the Respondent presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden then shifts to the Applicant which must then present its own evidence of medical necessity. Andrew Carothers, M.D., P.C. v. GEICO Indemnity Company, 2008 NY Slip Op 50456U, 18 Misc. 3d 1147A, 2008 N.Y. Misc. LEXIS 1121, West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co. 13 Misc.3d 131, 824 N.Y.S.2d 759, 2006 NY Slip Op51871(U) (Sup. Ct. App. T. 2d Dep't 2006)].

Applicant's evidence rebuts the conclusions set forth in the IME report. Pan Chiropractic P.C. v. Mercury Ins. Co., 24 Misc. 3d 136A (App Term, 2d, 11th & 13th Jud Dists 2009). *See also* Flushing Traditional Acupuncture, P.C. a/a/o AK v. GEICO Ins. Co., 36 Misc. 3d 156A, (App Term 2d Dept 2012). It is ultimately Applicant who must prove, by a preponderance of the evidence, the post-IME services in question were medically necessary. Dayan v. Allstate Ins. Co., 39 Misc.3d 151(A) (App. Term 2d, 11th & 13th Dists. 2015); Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co., 37 Misc.3d 19, 952 N.Y.S.2d 372. (App. Term 2d, 11th & 13th Dists. 2012). This was done herein. Applicant submits a report from 2/18/20. This report notes reduced range of motion in both the cervical and lumbar spines. There is a positive Spurling's test and Straight Leg Raise. There is pain noted in cervical and lumbar facets. Similar findings were noted on 3/17/20. These reports are sufficient to rebut the IME of Dr. Walsh.

Insurance Law § 5102(a)(1) defines "basic economic loss" as including "all necessary expenses incurred for...professional health services" subject to the limitations of Insurance Law § 5108. Insurance Law § 5108 limits the amounts to be charged by providers of health services, and states that charges for services specified in Insurance Law § 5102(a)(1) "shall not exceed the charges permissible under the schedules prepared and established by the chairman for the workers' compensation board...except where the insurer...determines that unusual procedures or unique circumstances justify the excess charge." 11 NYCRR § 65-3.16(a) provides that "[p]ayment for medical expenses shall be in accordance with fee schedules promulgated under section 5108 of the Insurance Law and contained in Part 68 of this Title (Regulation 83)." 11 NYCRR § 68.1 provides that the "existing fee schedules prepared and established by the chairman of the Workers' Compensation Board...are hereby adopted by the Superintendent of Insurance with appropriate modifications so as to adapt such schedules for use pursuant to section 5108 of the Insurance Law."

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).

Applicant billed for an outcome assessment test under CPT code 99358. Respondent submits a coder report from Crystal Russo, CPC who states that:

Evaluation and Management: Hospital Discharge Services, 96101, 96125 (Q & A) Question: "For patients being assessed for low back pain, some providers administer and then assess, and may over time follow with tests, such as the Roland-Morris Low Back Pain and Disability Questionnaire, the Oswestry Disability Questionnaire, and similar back or spinal assessment questionnaires. Can these be reported using codes 96101-96125, (Central Nervous System Assessments/Tests [e.g., Neuro-Cognitive, Mental Status, Speech Testing])? If not, how should these be reported?"

"Answer: Tests of this type are not separately reported using codes 96101-96125 or other CPT codes; instead, they are part of the Evaluation and Management (EIM) services provided. The tests are completed by the patient and in the public domain, so there are no additional supply costs and the provider work involved falls within the E/M services (or "evaluation" or "re-evaluation" codes for therapists), as part of the collection of information and assessment of the patient."

She also states that "Applicant improperly seeks reimbursement for Outcome Assessment testing ('OAT') billed under CPT code 99358. In reaching this conclusion, she states she reviewed the "Outcome Assessment Testing Summary" annexed as Exhibit B to her affidavit. Exhibit "B" to the affidavit is for a different patient and looks markedly different than the report supplied by the Applicant. Applicant's report is called "Pain Management Outcome Assessment report" and Respondent fails to indicate if this is the same as the assessment mentioned in the coder affidavit. Moreover, as the coder is indicating that CPT code 99358 cannot be reimbursed as this test is "self-administered" it is incumbent upon Respondent to review the actual test provided and not provide a generic affidavit. As such, I find that the affidavit is insufficient.

At the hearing, Respondent also argued that Applicant was not entitled to four units of CPT code 20553 as said CPT 20553 is defined as "single or multiple trigger point(s), 3 or more muscles". Respondent's argument is that, based upon a plain reading of the CPT code, Applicant is only entitled to one unit. However, no coder report was submitted to support this argument. Without a coder report, Applicant's report stands un rebutted. The claim is granted in full.

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
	Macintosh Medical, P.C.	02/18/20 - 02/18/20	\$1,837.92	Awarded: \$1,837.92
	Macintosh Medical, P.C.	03/17/20 - 03/17/20	\$1,837.92	Awarded: \$1,837.92
Total			\$3,675.84	Awarded: \$3,675.84

- B. The insurer shall also compute and pay the applicant interest set forth below. 06/01/2020 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

As this matter was filed on or 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) 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 dispute, subject to a maximum fee of \$1,360.

- 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 Suffolk

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

11/04/2021

(Dated)

Shawn Kelleher

#### **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:**  
87953d47361b02e1a902a2e5f86a9ffc

### **Electronically Signed**

Your name: Shawn Kelleher  
Signed on: 11/04/2021