

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Front Street Medical PC
(Applicant)

- and -

Progressive Casualty Insurance Company
(Respondent)

AAA Case No. 17-21-1199-6783

Applicant's File No. STLG20-53868

Insurer's Claim File No. 202836564

NAIC No. 32786

ARBITRATION AWARD

I, Alana Barran, 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: Patient

1. Hearing(s) held on 11/19/2021
Declared closed by the arbitrator on 11/19/2021

John Faris from Strauss Terry Law Group, PLLC participated for the Applicant

Ashley Sforza from Progressive Casualty Insurance Company participated for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 2,340.14**, 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 patient, MR, is a 31 year old male that was involved in an accident on 3/6/2020. This is a claim for physical therapy treatment and office visit to the patient from 3/17/2020 through 8/31/2020. The Respondent argues that the claim was properly paid based on the fee schedule; that a portion of the claim was not received by Respondent; and that a portion of the claim was denied based on the IME of Dr. Christopher Burrei. The issue raised is whether the Respondent sustained its defense based on the fee schedule; and whether a portion of the services were medically necessary.

4. Findings, Conclusions, and Basis Therefor

My decision is based on the arguments of the representatives for parties appearing and those documents contained in the ADR Center for this case.

The respondent denied the claim for services March 17, 2020 as applied against its deductible and submits the policy of insurance in support. I find that the claim for services of March 17, 2020 is not due as properly applied to the deductible under the policy of insurance. Therefore, the claim for services March 17, 2020 is denied.

The respondent argues that it properly paid for the services on 4/1/2020-6/19/2020 pursuant to the fee schedule. The Applicant billed the sum of \$446.85 of which the Respondent paid \$315.48 leaving a balance of \$145.40. The respondent submits the explanation of benefits and support of its argument which I find to be persuasive and sufficient that said services were properly paid at the fee schedule rate under a plain reading of the fee schedule effective at the time of treatment. Therefore, the claim for services on 4/1/2020-6/19/2020 is denied.

The applicant billed \$1,454.40 for services July 28, 2020 through August 31, 2020. The respondent argues that pursuant to a plain reading of the fee schedule the proper reimbursable amount for said services is \$676.00. I find the respondents arguments and prove to be sufficient that the proper reimbursable amount for services July 28, 2020 through August 31, 2020 is \$676.00 pursuant to a plane reading of the fee schedule.

While the Respondent raised an additional defense in its denial, in the absence of any proof, Respondent failed to establish that the fees charged were excessive and not in accordance with the Workers' Compensation fee schedule. See St. Vincent Medical Care, P.C. v. Country Wide Ins. Co., 2010 NY Slip Op 50488(U) (App Term 2d, 11th & 13th Dists. Mar. 19, 2010).

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

Respondent argues that the bills were proper paid under the fee schedule. I could take judicial notice of the workers' compensation fee schedule. See Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 20 (2d Dept. 2009); LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), 2011 NY Slip Op 51721(U) (App Term 2d, 11th & 13th Jud Dists. 2011); Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A), 2011 NY Slip Op 50040(U) (App Term, 1st Dept. 2011). A party seeking to have judicial notice taken should provide the arbitrator (or court) with sufficient information to permit the forum to take judicial notice, in the absence of which it is permissible to decline to take notice of the fee schedule. See Megacure Acupuncture, P.C. v. Clarendon Natl. Ins. Co., 33 Misc.3d 141(A), 2011 NY Slip Op 52199(U) (App Term 2d, 11th & 13th Jud Dists., Nov. 30, 2011). Here, I take judicial notice of the fee schedule in the instant case.

The Respondent argues that the bill for services 5/18/2020 and 5/20/2020 at issue is not overdue as it was not received by the Respondent prior to the filing for this arbitration. The Applicant does not submit proof to establish mailing of the claim at issue to the Respondent prior to the filing for his arbitration. The Applicant's request at the arbitration hearing to submit proof of mailing without a persuasive rationale for why it was not submitted prior to the hearing given that the claim was filed over six months before the hearing date. I find that the relevant credible evidence is insufficient to establish that the bill for services on 5/18/2020 and 5/20/2020 at issue were timely and properly mailed to the Respondent, that the Applicant has met its prima facie case, and that the bill is overdue. Therefore, the claim for services 5/18/2020 and 5/20/2020 is dismissed without prejudice.

The respondent relies on the IME of Dr. Christopher Burrei conducted on 7/13/2020 in denying the claim for services 7/28/2020-8/31/2020 at issue for lack of medical necessity. Dr. Burrei's examination states "I would note that his complaints far exceed any objective finding and he has global restriction of range of motion in the spinal examination; however, he is observed in the cervical spine to have an 80 degrees of rotary motion, 40 degrees of lateral flexion, and 60 degrees of forward flexion and extension. He reports diffuse palpatory tenderness. There is no focal tenderness. There is no spasm. There are no trigger points. There is no step-off the spinous processes. He reports pain in through the thoracic spine and the paraspinals but there is no spasm. There is no step-off the spinous region. There are no objective palpatory findings. He has full range of motion of the shoulders, elbows, wrists, and hands. There is no evidence of rotator cuff deficit. His lumbar exam, he is observed to sit fully upright with at least 60 degrees of flexion. Rotary motion and lateral flexion at 30 degrees bilaterally and extension is to 20 degrees. He has midline tenderness, nonspecific, non reproducible. He has a paraspinal tenderness nonspecific and non-reproducible. There is no spasm or trigger points. He has no pain in the SI joints. No pain in the sciatic notch. He has full range of motion of the hips, knees, and ankles. He is able to heel and toe rise." He concludes that the injuries are resolved and that no further treatment is medically necessary. He does not provide a persuasive rationale for his conclusory statement that the complaints far exceed any objective findings nor for the general statement that he has global restriction of range of motion in the spinal examination. He issued an addendum on October 20, 2021 after reviewing the rebuttal which I find to be unpersuasive and insufficient to sustain the respondent's defense. I find the IME findings to be general, conclusory, unpersuasive and insufficient to meet the Respondent's burden of proof to sustain its defense of lack of medical necessity.

The record in submission includes a rebuttal by Dr. Nirav Shah, P.T. dated 10/4/2021 evaluations dated 8/12/2020 with positive findings upon evaluation of the patient, 9/16/2020, 4/22/2020, 10/28/2020; soap notes without detailed examination of the patient. I find that the records in submission are persuasive and sufficient to rebut the findings of the IME doctor.

The applicant has established its initial entitlement to no fault benefits. The burden then shifts to the respondent. The respondent's denial for lack of medical necessity must be supported by a peer review or other competent medical evidence which sets forth a clear factual basis and medical rationale for denying the claim. Healing

Hands Chiropractic, P.C. v. National Assurance Co., 5 Misc. 3d 975; Citywide Social Work, et. al v. Travelers Indemnity Co., 3 Misc. 3d 608. The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 2009 NY Slip Op 00351 (App Div. 2d Dept., Jan. 20, 2009); Channel Chiropractic, P.C. v. Country-Wide Ins. Co., 2007 Slip Op 01973, 38 A.D.3d 294 (1st Dept. 2007); Bronx Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co., 2007 NY Slip Op 27427, 17 Misc.3d 97 (App Term 1st Dept., 2007).

In order for an applicant to prove that the disputed expense was medically necessary, it must meaningfully refer to, or rebut, the conclusions set forth in the peer review. Yklik, Inc. v. Geico Ins. Co., 2010 NY Slip Op. 51336(U) (App Term 2d, 11th & 13th Dists. July 22, 2010); High Quality Medical, P.C. v. Mercury Ins. Co., 2010 N.Y. Slip Op. 50447(U) (App Term 2d, 11th & 13th Dists. Mar. 10, 2010); Pan Chiropractic, P.C. v. Mercury Ins. Co., 24 Misc.3d 136(A), 2009 N.Y. Slip Op. 51495(U) (App Term 2d, 11th & 13th Dists. July 9, 2009).

I find the IME and addendum findings of Dr. Christopher Burrei has failed to set forth a sufficient factual basis and medical rationale for his opinion that the disputed services were not medically necessary and therefore has not established, *prima facie*, a lack of medical necessity for those services rendered by Applicant. The burden has not shifted to the Applicant and has nevertheless been rebutted. Therefore, the claim for 7/28/2020-8/31/2020 is granted in the sum of \$676.00.

Comparing the relevant evidence presented by both parties against each other and the above referenced standards, based on the foregoing, the Applicant is awarded the sum of \$676.00.

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	Status
	Front Street Medical PC	03/17/20 - 08/31/20	\$2,340.14	Awarded: \$676.00
Total			\$2,340.14	Awarded: \$676.00

- B. The insurer shall also compute and pay the applicant interest set forth below. 04/06/2021 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Where a claim is untimely denied, or not denied or paid, interest shall accrue as of the 30th day following the date the claim is presented by the claimant to the insurer for payment. Where a claim is timely denied, interest shall accrue as of the date an action is commenced or an arbitration requested, unless an action is commenced or an arbitration requested within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. (11 NYCRR 65-3.9(c)). The end date for the calculation of interest shall be the date of payment of the claim. In calculating interest, the date of accrual shall be excluded from the calculation. Where a motor vehicle accident occurs after April 5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. (11 NYCRR 65-3.9(a)). Where the claim is submitted electronically after the close of business or on the weekend, I find that the claim is deemed received on the next day of business following the electronic submission, and interest is awarded as of the next day of business following the electronic submission of the claim.

C. Attorney's Fees

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

For cases filed prior to February 4, 2015, 20 percent of the amount of first party benefits awarded herein, plus interest thereon, subject to a minimum of \$60 and a maximum of \$850. For cases filed on or after February 4, 2015, 20 percent of the amount of first party benefits awarded herein, plus interest thereon, subject to no minimum and a maximum of \$1360.(11NYCRR65-4).

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

01/08/2022
(Dated)

Alana Barran

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:
eb5d2b31ea7262237c3bb5a288f4f900

Electronically Signed

Your name: Alana Barran
Signed on: 01/08/2022