

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Macintosh Medical, P.C.
(Applicant)

- and -

Nationwide General Insurance Company
(Respondent)

AAA Case No. 17-21-1189-7868

Applicant's File No. JL20-121480

Insurer's Claim File No. 114036GK

NAIC No. 23760

ARBITRATION AWARD

I, Anthony Joseph Bianchino, 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 09/06/2022
Declared closed by the arbitrator on 09/06/2022

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

Brian Kaufman, Esq. from Hollander Legal Group PC participated for the Respondent

2. The amount claimed in the Arbitration Request, **\$4,099.48**, was AMENDED and permitted by the arbitrator at the oral hearing.

At the Hearing the Applicant's attorney reduced the amount in dispute to \$2,990.50 which the Applicant contends is the proper Fee Schedule amount.

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

3. Summary of Issues in Dispute

This matter involves a motor vehicle accident which occurred on January 16, 2020. As a result of the accident the patient [NG], a 36 year old female, sought medical treatment, which is detailed below.

The issue in dispute is whether the Applicant provided all of the reasonably requested additional verification with 120 days of the initial request for the examinations the patient had on June 11, 2020, August 6, 2020 and October 29, 2020, the outcome assessment testing done June 11, 2020, August 6, 2020 and October 29, 2020 and the trapezius trigger point injections with fluoroscopic guidance received on June 11, 2020 and August 6, 2020.

4. Findings, Conclusions, and Basis Therefor

The original amount in dispute was \$4,099.48; however at the time of the Hearing the Applicant's attorney reduced the amount in dispute to \$2,990.50 which is for three examinations in the amount of \$329.46, three dates of outcome assessment testing in the amount of \$688.94, two dates of trapezius trigger point injections with supplies in the amount of \$131.60 per date and fluoroscopic guidance for the trigger point injections in the amount of \$854.45 per date.

This matter falls under Section 65-4.2 (b)(3) of the No-Fault Regulations, "Rocket Docket" and as such only the documents submitted by the Applicant at the time of filing and by the Respondent during the conciliation will be considered. Therefore all documents contained in the Electronic Case Folder at the time of the Hearing have been considered.

This is a motor vehicle accident which occurred on January 16, 2020. As result of the accident the patient saw PA Kopach on June 11, 2020, August 6, 2020, September 10, 2020 and October 29, 2020. On June 11, 2020, August 6, 2020, September 10, 2020 and October 29, 2020 the patient had outcome assessment testing. On June 11, 2020, August 6, 2020 and September 10, 2020 the patient received trapezius trigger point injections with fluoroscopic guidance which were performed by PA Kopach.

On April 30, 2020 Dr. Landow appear for an Examination Under Oath with regard to treatment rendered to nineteen patients. Upon receipt of the NF-3s for the treatment in this case the Respondent timely sent a letter to the Applicant requesting the following items of additional verification:

[1] A copy of the fully executed lease agreement(s) for the following locations: 332 E 149th Street, Suite 200, Bronx, New York; 647 Bryant Ave., Bronx, New York; 430 West Merrick Road, Valley Stream, New York; 3407 White Plains Road, Bronx, New York; 513 Church Avenue, Brooklyn, New York; 82-25 Queens Blvd., Queens, New York; 1320 Louis 9 Blvd., Bronx, New York; 4250 White Plains Road, Bronx, New York; 1120 Morris Park Ave., Bronx, New York; and 4014A Boston Road, Bronx, New York.

[2] For each of the locations where Macintosh rendered services in the year 2020, including but not limited to the locations above, proof of any and all rent payments made for each location from the time period of January 2020, through the present;

[3] A copy of the partially executed sublease agreement for the 3910 Church Ave., Brooklyn, New York location where Macintosh rendered/renders services in 2020;

[4] Proof of any rent payments made in 2020 with respect to the 3910 Church Ave., Brooklyn, New York location;

[5] A copy of the employment agreement entered into between Macintosh Medical P.C. and the following individuals, along with any other employment agreements between the individuals and any P.C. of Dr. Landow which were assigned or transferred to Macintosh Medical P.C.; Vivane Etienne, M.D.; Alex Kopach, PA; Mario Leon, PA; Ajin Matthew, PA; Claudia Geris, PA; Wei Hong Xu, NP; Jeff Marcellis, PA; Joyce Malks, PA; Kanny Kamrunahar; and Kamla Mohan.

[6] A copy of the fully executed IRS Form W-4 with respect to Macintosh Medical P.C. for the following individuals: Vivane Etienne, M.D.; Alex Kopach, PA; Mario Leon, PA; Ajin Matthew, PA; Claudia Geris, PA; Wei Hong Xu, NP; Jeff Marcellis, PA; Joyce Malks, PA; Kanny Kamrunahar; and Kamla Mohan.

[7] A copy of the fee-for-service fee schedule between Macintosh Medical P.C. and the following individuals: Vivane Etienne, M.D.; Alex Kopach, PA; Mario Leon, PA; Ajin Matthew, PA; Claudia Geris, PA; Wei Hong Xu, NP; Jeff Marcellis, PA; and Joyce Malks, PA.

[8] A copy of the schedule of Dr. Viviane Etienne maintained by Macintosh Medical P.C. indicating the dates and locations where she either saw patients or was physically present on behalf of Macintosh Medical P.C.;

[9] A copy of the schedule of Dr. Jonathan Landow maintained by Macintosh Medical P.C. indicating the dates and locations where he either saw patients or was physically present on behalf of Macintosh Medical P.C.; Proof of any travel to the New York State area, including but not limited to plane tickets, in the year 2020 as it relates to Dr. Jonathan Landow;

[10] A copy of the signature card for the bank account of Macintosh Medical P.C. at TD Bank;

[11] A copy of Macintosh Medical, P.C. banking statements from the time period of January 2020 through the present;

[12] A copy of the agreement entered into between Macintosh Medical P.C. and Green Bills;

[13] A copy of any and all invoices provided to Macintosh Medical P.C. by Green Bills for the year 2020;

[14] Proof of any and all payments made by Macintosh Medical P.C. to Green Bills in the year 2020; A copy of any and all forms utilized by Macintosh Medical P.C. on the letterhead of the P.C. for referrals for MRIs;

[15] A copy of any and all forms utilized by Macintosh Medical P.C. on the letterhead of the P.C. for referrals for DME;

[16] A copy of any and all forms utilized by Macintosh Medical P.C. on the letterhead of the P.C. for referrals for any other services or testing;

[17] A copy of any medical literature and/or studies supporting the use of Omeprazole when NSAIDs are prescribed; A copy of any medical literature and/or studies supporting the use of Diclofenac 3% for patients involved in automobile accidents, patients with soft tissue injuries, for use on the spine, hip, or shoulder, or for any other uses prescribed by Macintosh Medical P.C.;

[18] A copy of the Workers Compensation Declarations pages for policy maintained by Macintosh Medical P.C.;

[19] A Proof of any loans made to Macintosh Medical P.C. by any other P.C. for which Dr. Landow maintains an ownership interest;

[20] A copy of the agreement entered into between Macintosh Medical P.C. and Dynamic Solutions; Proof of any and all loans made to Macintosh Medical P.C. by Dynamic Solutions including proof of any checks and/or electronic transfers made to the P.C.;

Due to the Applicant not responding to the Respondent's requests for additional verification the Respondent timely sent a letter to the Applicant re-requesting the additional verification. Following the second request the Applicant, within 120 days of the initial request, objected to the Respondent's entire request for additional verification. However "as a good faith showing of its intent to cooperate" the Applicant partially responded to the Respondent's request for additional verification. Due to the Applicant not completely responding to the Respondent's requests for additional verification, after 120 days of the initial request, the Respondent denied the Applicant's claim for the examination, the outcome assessment testing and the trigger point injections with fluoroscopic guidance in dispute stating: "Nationwide is denying your claim for failure to provide the requested verification or written proof providing reasonable justification for the failure to comply within 120 calendar days after our initial request...."

Section 65-3.5 (b) of the No-Fault Regulations states: "Subsequent to the receipt of one or more of the completed verification forms, any additional verification required by the insurer to establish proof of claim shall be requested within 15 business days of receipt of the prescribed verification forms."

Section 65-3.6 (b) of the No-Fault Regulations states: "Verification requests. At a minimum, if any requested verifications has not been supplied to the insurer 30 calendar days after the original request, the insurer shall, within 10 calendar days, follow up with the party from whom the verification was requested, either by telephone call, properly documented in the file, or by mail. At the same time the insurer shall inform the applicant and such person's attorney of the reason(s) why the claim is delayed by identifying in writing the missing verification and the party from whom it was requested."

Section 65-3.5 (o) of the No-Fault Regulations states: "An applicant from whom verification is requested shall, within 120 calendar days from the date of the initial request for verification, submit all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. The insurer shall advise the applicant in the verification request that the insurer may deny the claim if the applicant does not provide within 120 calendar days from the date of the initial request either all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. This subdivision shall not apply to a prescribed form (NF-Form) as set forth in Appendix 13 of this Title, medical examination request, or examination under oath request. This subdivision shall apply, with respect to claims for medical services, to any treatment or service rendered on or after April 1, 2013 and with respect to claims for lost earnings and reasonable and necessary expenses, to any accident occurring on or after April 1, 2013."

It is undisputed that the Respondent upon receipt of the NF-3s for the services in dispute made two timely requests for additional verification. Further it is also undisputed that the Applicant did respond to the Respondent's request for additional verification by objecting to the request as being unreasonable and by providing some of the items requested. The Applicant's attorney at the Hearing and in their brief argued that pursuant to Section 65-3.2 "Claim practice principals to be followed by all insurers" an insurer should "not demand verification of facts unless there are good reasons to do so." The Applicant's attorney goes to claim that since Dr. Landow testified at an Examination Under Oath and since the Respondent has not put a valid reason for requesting the post Examination Under Oath additional verification, the Respondent's denial is invalid. While I agree with the Applicant's attorney that an insurer should not demand verification unless there are good reasons to do so, in this case each item of additional verification must be evaluated on its own and not collectively with the other items requested.

Therefore the issues that must be resolved are whether the Respondent's request for each item of outstanding additional verification was reasonable and whether the items of additional verification provided by the Applicant were sufficient. In performing the analysis of which items of additional verification, if any, were

reasonable, the Respondent's request can be divided into four categories. Category I are those items that relate to whether the Applicant was properly licensed and whether the Applicant was involved in kickbacks with other providers; Category II are those items that relate to treatment, Category III are those items that relate to the Fee Schedule and Category IV are those items that relate to the employment status of those individuals that rendered treatment to the patient.

In dealing with Category I, the following items of additional verification, requested by the Respondent fall into this category: 1, 2, 3, 4, 9, 10, 11, 12, 13, 14, 19 and 20.

The Court of Appeals in case of State Farm Mutual Insurance Co. v. Mallela 4 N.Y.3d 313, 794 N.Y.S.2d 700 in addressing the Respondent's right investigate a provider's license status held: "Indeed, the Superintendent's regulations themselves provide for agency oversight of carriers, and demand that carriers delay the payment of claims to pursue investigations solely for good cause (*see 11 NYCRR 65-3.2 [c]*). In the licensing context, carriers will be unable to show "good cause" unless they can demonstrate behavior tantamount to fraud."

Therefore under Mallela in order for a Respondent's request for additional verification, to inquire into the Applicant's licensing status, to be reasonable the Respondent must "show good cause" by putting forth proof that demonstrates "behavior tantamount to fraud."

The Respondent in support of their position that they required the additional verification in Category I, relies upon Dr. Landow's Examination Under Oath testimony. Specifically Dr. Landow's testimony that he a resident of Florida; however he was able to start eight to ten treatment locations in New York. In reviewing Dr. Landow's Examination Under Oath testimony I do not find anything which would suggest "behavior tantamount to fraud" and as such the Respondent did not have good cause to request any of the items in Category I that relate to whether the Applicant was properly licensed. The fact that Dr. Landow is a Florida resident in no way in an indication that he is not the owner of the Applicant. Moreover there is absolutely nothing in Dr. Landow's testimony to suggest that the Applicant was involved in any type of kickback with regard to the specific services rendered to the patient in this case.

Regarding with Category II, I find that the following items of additional verification fall into this category; 15, 16 and 17. Here the items of additional verification requested in 15, 16 and 17 of the Respondent's request for additional verification relate to DME referrals, testing referrals and literature with regard to Diclofenac gel. Since the services in dispute in this case have absolutely nothing to do with DME referrals, outside testing and prescription medication I find that this request is palpably improper.

In dealing with Category III, I find that item 8 of additional verification falls into this category. The Respondent argues that the requested additional verification in item 8, which is Dr. Etienne's work schedule, was needed to determine whether the Dr. Etienne was present at the location where the patient was receiving treatment on

each date of service. The basis of this request is Ground Rule 11 A, contained in the General Ground Rules Section of the 2012 Fee Schedule which requires "Physician Supervision" for a PA to bill for services. In this case both the examination and the trapezius trigger point injections were done by PA Kopach; however since Dr. Etienne did sign the trigger point injections report, I find that to be an indication that she was present at the time the services were rendered, which would make Dr. Etienne's work schedule completely irrelevant.

In dealing with Category IV which relates to the employment status of each provider rendering care to the patient, I find that the following items of additional verification fall into this category; 5, 6, 7 and 18. It is well settled that a PC can only bill for services rendered by an employee of the PC and if the individual rendering the services is an independent contractor the PC can not bill for the services, see A.M. Med. Servs., P.C. v. Progressive Cas. Is. Co., 101 A.D.3d 53, 58-62. At the Hearing the Applicant's attorney argued that this request for additional verification is unreasonable since Dr. Landow testified that each individual that rendered treatment at the Applicant's facilities was an employee of the PC and since each NF-3 in Box 16 specifically states that each individual was an employee. While each NF-3 notes that Dr. Etienne was an employee, the NF-3s make no reference to the PA who rendered treatment for which the Applicant is billing. Moreover regardless of Dr. Landow's testimony and the NF-3s, an individual's employment status can be considered part of a provider's prima facie case, since it is a question listed on an NF-3. As such I find that an insurer has a right to verify through documentation one's employment status. Therefore the Respondent's general request as it relates to the individuals who rendered services to the patient, including Dr. Etienne, employment status was a relevant request for additional verification.

Although the Respondent requested the employment agreements between the Applicant and each of the individuals that rendered treatment, each individual's W-4, a "fee for service" schedule between the Applicant and each individual rendering treatment and the declarations page for the Applicant's Workers' Compensation Policy in order to verify the employment status of each individual rendering treatment; the only relevant requested item of the four would be each individual's, who rendered treatment, W-4. Here while the Applicant did provide the W-4's for Dr. Etienne and PA Kopach; the Respondent's attorney argued that the W-4s were not sufficient to show that Dr. Etienne and PA Kopach were employees of the Applicant at the time the services were rendered. The Respondent's attorney points out the W-4s for Dr. Etienne and PA Kopach do on list the social security numbers, the name of the employer, the first date of employment and the employer's identification number. Here even though the social security number for Dr. Etienne and PA Kopach is missing, which is not critical; the fact that the name of the employer, first date of employment and the employer's identification are missing on the W-4s, I find that the W-4s submitted do not satisfy the Respondent's request for additional verification.

While nineteen out of the twenty items of the Respondent's request for additional verification were unreasonable, the fact that the Applicant did not provide a completed W-4, which lists the name of the employer, the first date of employment and

the employer identification number I find that the Applicant did not fully respond to the Respondent's request for the relevant items of additional verification within 120 days of the initial request.

Accordingly the Applicant's claim for the examinations conducted on June 11, 2020, August 6, 2020 and October 29, 2020, the outcome assessment testing done on June 11, 2020, August 6, 2020 and October 29, 2020 and the trapezius trigger point injections with fluoroscopic guidance received on June 11, 2020 and August 6, 2020 is denied.

This is in full disposition of all No-Fault benefit claims submitted to the 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 claim is DENIED in its entirety

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

09/08/2022
(Dated)

Anthony Joseph Bianchino

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:
c544e168e1917e0bab246f1309ee45d6

Electronically Signed

Your name: Anthony Joseph Bianchino
Signed on: 09/08/2022