

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Surgicore Of Jersey City, LLC
(Applicant)

- and -

Hereford Insurance Company
(Respondent)

AAA Case No. 17-21-1192-9177

Applicant's File No. N/A

Insurer's Claim File No. 90112-01

NAIC No. 24309

ARBITRATION AWARD

I, Ioannis Gloumis, 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 07/25/2022, 09/30/2022
Declared closed by the arbitrator on 09/30/2022

Kim Gitlin, Esq. from Dino R. DiRienzo Esq. participated for the Applicant

Andrew Schiavone, Esq. from Law Offices of Rubin & Nazarian participated for the Respondent

2. The amount claimed in the Arbitration Request, **\$5,971.14**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated to the timeliness of Respondent's denial of the claim in dispute and that the issues to be determined are whether Respondent's denial of the claim based upon the defenses of lack of medical necessity and that Applicant's charges are not in accordance with the fee schedule should be upheld.

3. Summary of Issues in Dispute

Applicant seeks reimbursement of charges related to Ambulatory Surgery Center ("ASC") fees in connection a right knee arthroscopy that was performed upon the EIP at

Applicant's Surgicenter on June 22, 2020, following a February 22, 2020 motor vehicle accident. Respondent denied the claim based upon the defenses of lack of medical necessity and that Applicant's charges exceeded the maximum allowance under the applicable fee schedule.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the submissions contained in the American Arbitration Association's Electronic Case Folder in MODRIA, said submissions constituting the record in this case. This award is based upon the arguments that were presented by the parties during the arbitration hearing and the admissible documentary evidence submitted by the parties. There were no witnesses that testified during the arbitration hearing.

SUMMARY OF FACTS

The EIP, then a 53-year-old male pedestrian, was injured when he was struck by the insured motor vehicle on February 22, 2020. Following the accident, the EIP went to the emergency department of Mount Sinai Hospital of Queens, where he was evaluated, treated, and later discharged. Thereafter, the EIP sought private medical attention for injuries to the knees, neck, shoulders, and back. The EIP came under the care of multiple providers and underwent conservative care. The EIP subsequently came under the care of Ashley Simela, D.O. for continued complaints of pain in the right knee. Dr. Simela performed a right knee arthroscopy at Applicant's ASC in New Jersey on June 22, 2020.

Applicant billed Respondent the total amount of \$5,971.14 for the ASC fees in connection with the right knee surgery that was performed on June 22, 2020. Applicant billed Respondent using CPT Codes 29880 RT, G0289 59 RT, and 29876 59 RT. Respondent's evidence shows that Applicant's bill was received by Respondent on July 23, 2020.

LEGAL STANDARDS FOR PRIMA FACIE CASE

To establish a prima facie case, an applicant is required to submit proof that it timely sent its claim for no-fault benefits to the insurer, that the insurer received the claim, and that defendant failed to pay or deny the claim within 30 days. See *Amaze Med. Supply Inc. v Allstate Ins. Co.*, 3 Misc.3d 133(A) (App Term, 2d & 11th Jud Dists 2004); *King's Med. Supply Inc. v Country-Wide Ins. Co.*, 5 Misc.3d 767 (Civ Ct, NY County 2004).

An insurer's denial of claim form indicating the date on which it was received adequately establishes that the applicant sent, and that the insurer received the claim. *Ultra Diagnostics Imaging v. Liberty Mutual Ins. Co.*, 9 Misc.3d 97 (App. Term 9th & 10th Dists. 2005).

APPLICATION OF LEGAL STANDARDS TO THE CLAIM

Since the evidence shows that Applicant's bill for the claim was received by Respondent on July 23, 2020, I find that Applicant has established its prima facie case. Moreover, Applicant stipulated that Respondent timely denied the claim on December 23, 2020 following the receipt of final verification on December 1, 2020. Respondent denied the claim based upon the defenses of lack of medical necessity and that Applicant's charges are not in accordance with the fee schedule.

DEFENSE - LACK OF MEDICAL NECESSITY

Peer Review Report - Julio Westerband, M.D. (December 21, 2020)

Dr. Westerband opined that the right knee surgery performed on June 22, 2020 was not medically necessary. Dr. Westerband stated that the medical records show that the EIP received 28 sessions of physical therapy in three months for the right knee. He opined that if the care had been for three months nonstop, then that may have sufficed; however, if the care has not been constant, six-month physical therapy is required before arriving at a conclusion that a surgery is required. Dr. Westerband noted that in this case, intermittent physical therapy was provided in the concerned region, but the surgical decision was made before completing the six months of physical therapy. Additionally, Dr. Westerband noted that the EIP received a cortisone injection to the

right knee on April 28, 2020; however, up to three cortisone injections should be provided in a span of a 12-month period for claimant to expected to improve with nonsurgical treatment. Dr. Westerband opined that an adequate attempt at conservative care, including physical therapy sessions for 3 to 6 months, along with judicious use of up to three cortisone injections, could have resolved most of the symptoms, nullifying the need for the right knee arthroscopy. Therefore, it is Dr. Westerband's opinion that the right knee arthroscopy was not medically necessary. Dr. Westerband cited to medical literature.

Additionally, Dr. Westerband opined that the findings identified in the MRI of the right knee that was performed on March 4, 2020 do not necessitate surgery; the correct and adequate treatment for the diagnosed condition should have been provided; these findings could be managed with a nonoperative course of treatment; and arthroscopic surgery for the clinical picture depicted in this case along with the findings in the MRI was not medically necessary. Dr. Westerband opined that the findings could have been easily treated with adequate and continuous physical therapy sessions along with up to three cortisone injections.

Medical Evidence

The June 9, 2020 examination report from Dr. Simela noted that the EIP presented with persistent pain in his right knee and was evaluated by an orthopedic physician who also indicated the need for surgery; however, the EIP was not able to have the surgery due to the Covid-19 pandemic. The EIP reported worsening right knee pain, with swelling, locking, and catching. The physical examination revealed a positive McMurray's test, medial and lateral joint line tenderness, patellar crepitus, and soft tissue swelling along the medial gastrocnemius. Range of motion was measured at full extension 0 degrees and flexion 100 degrees. Dr. Simela noted that the MRI dated March 4, 2020 noted mild effusion, a bony contusion, a partial tear of the medial head of the gastrocnemius, a partial tear of the medial collateral ligament, a chronic ACL tear, and a partial tear involving the superior articular surface of the lateral meniscus. The impression consisted of internal derangement with meniscal tear and medial collateral ligament damage of the right knee. Dr. Simela opined that the EIP clearly had a symptomatic right knee injury following trauma and the patient would benefit from arthroscopy with possible repair of the medial collateral ligament and/or meniscus, and possible reconstruction of the ACL.

The overall evidence shows that the EIP received physical therapy, high powered k-laser therapy, and an ultrasound guided cortisone injection to the right knee prior to the surgical intervention.

The operative report from the right knee surgery that was performed on June 22, 2020 provides a pre-operative diagnosis of meniscus tear and post-operative diagnoses of meniscus tear, synovitis, and a partial ACL tear. The operative report also notes that Dr. Simela performed a partial medial meniscectomy, a partial lateral meniscectomy, chondroplasty, and subtotal synovitis. In the indications for surgery section, Dr. Simela stated that the EIP is a 53-year-old male who sustained trauma to his right knee and despite an extensive course of conservative treatment, which included therapy, oral pain medications, and injections, his symptoms did not improve; and the MRI obtained revealed a meniscus tear.

LEGAL STANDARDS FOR DEFENSE OF LACK OF MEDICAL NECESSITY

It is well established that the burden is on the insurer to prove that the medical treatment was medically unnecessary. See *A.B. Med. Servs., PLLC v GEICO Ins.*, 2 Misc.3d 26 (App Term, 2d & 11th Jud Dists 2003); *King's Med. Supply Inc. v Country-Wide Ins. Co.*, 5 Misc.3d 767, 772.

A denial premised on lack of medical necessity must be supported by competent evidence such as an independent medical examination, a peer review or other proof which sets forth a factual basis and a medical rationale for denying the claim. See *Amaze Med. Supply Inc. v Eagle Ins. Co.*, 2 Misc.3d 128(A) (App Term, 2d & 11th Jud Dists 2003); *King's Med. Supply Inc. v Country-Wide Ins. Co.*, 5 Misc.3d 767, 771.

Where the insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the claimant, which must then present its own evidence of medical necessity. See *Prince, Richardson on Evidence* §§ 3-104, 3-202 (Farrell 11th ed); *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.*, 13 Misc.3d 131(A) (2006).

DECISION

Following a complete review of the admissible evidence presented, I find in favor of Applicant. I am not persuaded by the peer review report of Dr. Westerband in this case and defer to the recommendation of Dr. Simela. Dr. Westerband opined that the right knee surgery of June 22, 2020 was not medically necessary as recommended and performed because sufficient conservative treatment had not been performed prior to the

surgical intervention, and had an adequate attempt of conservative treatment been performed, "most" of the symptoms could have been resolved. Dr. Westerband acknowledged that the EIP received 28 physical therapy treatments for the right knee over the course of three months. Dr. Westerband also acknowledged that the EIP received a cortisone injection. The evidence also shows that high powered k-laser therapy was performed upon the right knee prior to the surgery. Dr. Simela stated that the EIP presented on June 9, 2020 with complaints of worsening right knee pain with swelling, locking, and catching. Dr. Simela opined that the EIP would have benefited from an arthroscopy with possible repair of the medial collateral ligament and/or meniscus, as well as possible ACL reconstruction. The operative report confirmed the postoperative diagnoses of meniscus tear, synovitis, and a partial ACL tear. Dr. Simela performed partial medial and lateral meniscectomies, chondroplasty, and subtotal synovitis. Dr. Westerband's statement that *most* of the symptoms could have been resolved with additional conservative care does not establish that continued conservative treatment with additional cortisone injections would have resolved the EIP's injuries from the accident and would have returned the EIP to pre-accident status. Moreover, I am not persuaded that Dr. Simela deviated from the generally accepted standard of care in performing the right knee surgery at that juncture of the treatment program, after the EIP had attempted conservative care, which included physical therapy, medications, laser therapy, and a cortisone injection for the right knee. Therefore, Respondent's denial of the claim should not be upheld in this case.

DEFENSE - APPLICANT'S CHARGES WERE NOT IN ACCORDANCE WITH THE APPLICABLE FEE SCHEDULE

Respondent has presented the affidavit of Carolyn Mallory, a Certified Professional Coder. Coder Mallory attested that the 33rd Amendment to Regulation 83 limits reimbursement to the lowest of (1) the amount of the fee in the region in New York State that is 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. Coder Mallory further stated that the changes in the 33rd Amendment of Regulation 83 went into effect on January 23, 2018 and would be applicable to the claims with the date of service occurring on or after January 23, 2018. She further stated that the services were performed in New Jersey; that the EIP's zip of address on the UB04 is 11337, which is in New York; therefore, the 33rd Amendment to Regulation 83 and the New York Fee Schedule would apply.

Applying the New York Workers' Compensation Board Enhanced Ambulatory Patient Groups Fee Schedule (hereinafter "EAPG"), which is effective for treatment rendered on or after October 1, 2015, Coder Mallory opined that the proper EAPG reimbursement is \$3,026.24 for CPT Code 29880 and CPT Codes G0289 and 29876 are not reimbursable because modifier 59 is not appropriate in this case.

Applicant did not present an affidavit or fee audit from a certified professional coder, medical billing expert, or medical professional in rebuttal to the affidavit of Coder Mallory or in support of the remaining charges in dispute.

LEGAL STANDARDS FOR FEE SCHEDULE DEFENSES

It is Respondent's 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 (Civil Ct, Kings Co. 2006). See also, *Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co.*, 11 Misc.3d 1065A (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, Respondent's defense of noncompliance with the appropriate fee schedules cannot be sustained. See *Continental Medical PC v. Travelers Indemnity Co.*, 11 Misc.3d 145A (App. Term, 1st Dep't, per curiam, 2006).

A Respondent may interpose a defense in a timely denial that the claim exceeds the fees permitted by the Workers' Compensation schedules, but Respondent must, at minimum, establish, by evidentiary proof, that the charges exceeded that permitted by law. *Abraham v. Country-Wide Ins. Co.*, 3 Misc.3d 130A (App. Term, 2d Dept. 2004).

DECISION

Respondent has presented sufficient evidence from a certified professional coder that establishes that Applicant, an ASC, would be entitled to the New York EAPG allowance of \$3,026.24. Ms. Mallory opined that Modifier 59 was not appropriately used based on the operative report, which demonstrates that all services were performed to the same anatomic site, at the same operative session. Following a complete review of the

evidence presented, I find that Applicant should be reimbursed for its claim in accordance with the New York EAPG's allowance of \$3,026.24 in accordance with the 33rd Amendment to Regulation 83. Applicant has failed to successfully rebut the opinion of Coder Mallory and to establish that it properly billed for its charges, or that it is entitled to any additional amount for the charges related to the claim.

Accordingly, Applicant's claim is hereby granted in the amount of \$3,026.24.

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
	Surgicore Of Jersey City, LLC	06/22/20 - 06/22/20	\$5,971.14	Awarded: \$3,026.24
Total			\$5,971.14	Awarded: \$3,026.24

- B. The insurer shall also compute and pay the applicant interest set forth below. 02/02/2021 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 Applicant the amount of interest computed from the date of filing, 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)*(stay of interest).

C. Attorney's Fees

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

Respondent shall also pay Applicant an attorney's fee in accordance with *11 NYCRR 4.6*.

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

10/29/2022
(Dated)

Ioannis Gloumis

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:
fe3181cd776b10499628b8c3942ebd34

Electronically Signed

Your name: Ioannis Gloumis
Signed on: 10/29/2022