

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Lenox Hill Hospital (NSUH)
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No. 17-21-1197-6811
Applicant's File No. RFA21-295483
Insurer's Claim File No. 0615856110101013
NAIC No. 35882

ARBITRATION AWARD

I, Phyllis Saxe, 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(FS)

1. Hearing(s) held on 01/05/2023
Declared closed by the arbitrator on 01/05/2023

Alexander Mun, Esq. from Russell Friedman & Associates LLP participated for the Applicant

Phillippa Tapada, Esq. from Geico Insurance Company participated for the Respondent

2. The amount claimed in the Arbitration Request, **\$14,550.37**, 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

This no-fault arbitration arises from an accident where FS, a pedestrian, was struck by a car on 11/27/18. FS was taken from the accident scene to Westchester Hospital, where she was diagnosed with a left shoulder clavicular fracture, a broken nose, and other soft tissue spinal injuries. The Assignor (FS) was then a 15-year-old female. FS sustained injuries from the accident and sought medical treatment from various clinicians. On 6/28/19, the Insurer retained Dr. Walsh to perform an orthopedic examination, after which Dr. Walsh terminated further medical and orthopedic treatment and deemed that FS's orthopedic injuries resolved.

On 8/26/20, FS was admitted to the Lenox Hill Facility to have the clavicle plates and screws removed from her shoulder. This bill seeks payment for the facility fee related to

that procedure. In response to receipt of the timely bill, the Insurer denied the claim based on Dr. Walsh's IME report of 6/18/19. During the hearing, Ms. Tapada asked me to consider other defenses to payment. Counsel argued that the patient was 17 years old at the time of the surgery and, therefore a minor whose AOB might lack legal effect if the mother did not obtain an Order from a Supreme Court Justice under the CPLR permitting her to execute arbitrate on FS's behalf.

The parties also discussed a near-policy exhaustion issue. Both parties stipulated that there was \$3,322.01 of funds left on the policy. However, both parties also agreed that if the claim was awarded, regardless of whether I agreed with the Applicant or Geico's fee schedule amount, there were sufficient funds remaining to pay the correct amount of the award.

4. Findings, Conclusions, and Basis Therefor

The decision below is based on documentary evidence maintained in electronic form and oral arguments presented by both parties' representatives during the hearing. The hearings were conducted via Zoom. Pursuant to 11 NYCRR 65-4.5 (o) (1) (regulation 68D), the arbitrator shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to legal rules of evidence shall not be necessary.

The Necessity of a Court Order

As a threshold matter, the Insurer argues that a Court Order is required for this arbitration to proceed. This record shows that the father and minor-patient signed the consent form and the father signed the AOB. Respondent argued that this case must be dismissed pursuant to CPLR 1209.

CPLR SEC. 1209 provides " A controversy involving an infant, person judicially declared to be competent or conservatee shall not be submitted to arbitration except pursuant to a court order made upon application of the representative of such infant, incompetent or conservatee; provided, however, that a claim brought on behalf of an infant pursuant to paragraph 102 of subdivision (app) of section 3420 of the insurance law may be submitted to arbitration without a court order."

I find that CPLR 1209 need only be complied with when the infant is the party to the arbitration. The parent, as the biological/legal guardian, has the legal right to make contractual decisions on the infant's behalf, including the decision to engage in medical treatment, the right to enroll and pay for the child's education and other consequential issues that arise. The parents act and execute contracts in the child's best interest without having to seek court approval for various issues.

The only time a parent requires court permission is when the child is a party to the lawsuit. Although the instant arbitration arises out of injuries sustained by a minor, the

minor is not a party to this arbitration. Instead, the evidence in the form of an Assignment of Benefits shows the rights to the disputed claim have been assigned to the applicant.

Further, as persuasively stated by Master Arbitrator Richard B. Ancowitz in Priority Health & Wellness of Montvale, LLC v. Allstate Fire & Casualty Ins. The applicant brings Co., AAA Case No. 99-15-1007-7594 (2016), the claim as an assignee of rights obtained from the infant's parent/guardian. In Priority v. Allstate, Master Arbitrator Ancowitz stated:

While CPLR 1209 requires that an arbitration claim which is "involving" an infant must first obtain a court order prior to proceeding, it is illogical to extend the definition of "involving" to the claim at issue here. This claim was brought to arbitration by applicant, not by a minor, and was based upon an assignment of the rights of the infant's parent/guardian. Nor was the claim based upon an assignment of rights from the minor, since the minor had no rights which could be legally assigned. Specifically, I find that no right of any infant could possibly be affected herein, and thus there is no logical reason to require the applicant to seek judicial intervention in order to ostensibly protect an infant's rights, where there are simply no rights to protect.

CPLR 1209 certainly does not compel such an illogical result. This is not to suggest that CPLR 1209 does not apply to arbitration proceedings generally - it certainly may, depending upon the circumstances. However, given the facts presented here, this claim was the applicant's, not the infant's, and did not involve the legal rights of the infant such as would require judicial intervention to protect the rights of the infant as per CPLR 1209. Further, the obligation, if any, to pay an infant's medical bills is the parent/guardians', not the infants' (Chernick v. Hartford Acc. & Ind. Co., 8 AD 2d 264), and hence there is no reason not to arbitrate a parent's claim which has been assigned to a provider. As an aside, it should be noted that requiring a court order pursuant to CPLR 1209 under these facts would also be inconsistent with the goal of the no-fault system to efficiently pay first party benefits. E.g. Presbyterian Hosp. v. Maryland Cas. Co., 90 N.Y.2d 274, 284 (1997). This is especially true where there are no rights of an infant which a court order could conceivably safeguard."

Further, in an article 75 proceeding titled NY Med a/a/o Tanise Washington v. Government Employees Ins. Co., Index No. 700058/15 (Sup. Ct., Queens Cty., 2015), Hon. Rudolph E. Greco, Jr. stated:

Case law has interpreted the language of CPLR § 1209 to find applicability only where the infant is actually a party to the action, (see Schneider v Schneider, 24 AD2d 768 [2d Dept. 1965]; see also Goldberg v Goldberg, 25 AD2d 670 [2d Dept. 1966]). In this instance, the infant Washington assigned her no fault benefits to petitioner and as such divested all control and right to the claim, (see Cardtronics, LP v St. Nicholas Beverage Discount Ctr., Inc., 8 AD3d 419, 420 [2d Dept. 2004]; see also Fairchild Hiller Corp. V McDonnell Douglas Corp., 28 NY2d 325, 330-31 [1971]). Accordingly, she was no longer a party to the action

and the petitioner assignee was the proper party in interest, (see Cardtronics, LP at 420; see also Jean v Joseph, 41AD3d 657, 658 [2d Dept. 2007]). As such, CPLR 91209 does not apply.

I agree with the analysis stated above, and thus this arbitration may proceed. Further, I note there is no evidence the respondent objected to the AOB before this arbitration. See Hospital for Joint Diseases v. Travelers Property Casualty Ins. Co., 9 NY3d 312 (2007).

The IME Defense

A health care provider-Applicant establishes its prima facie entitlement to No-Fault benefits by submitting proof that its claim, on the statutory billing form, was mailed and received by the, insurance company and that payment is overdue. Viviane Ettiene Med. Care, P.C. v. Country-Wide Ins. Co., 25 N.Y. 3d 498, 14 N.Y.S. 3d 283 (2015).

In order to establish a medical necessity defense, an insurer must present a sworn-to peer review or an independent medical review report which sets forth a factual basis and medical rationale for the doctor or professional's opinion that the services were not medically necessary. Pan Chiropractic, P.C. v. Mercury Ins. Co., 24 Misc. 3d 136(A), 897 N.Y.S. 2d 671 (App. Term, 2d, 11 and 13 Jud. Dists. 2009); Elmont Open MRI & Diagnostic Radiology, P.C. v. Tri-State Consumer Ins. Co., 34 Misc. 3d 141(A), 950 N.Y.S. 2d 491 (Table)(App. Term 9 and 10 Jud. Dists. 2012). Where an insurer-Respondent's IME doctor establishes a medical rationale for his or her stated conclusion that an Assignor's injuries were resolved and no further treatment was necessary, it is incumbent upon the Applicant-provider to rebut such a conclusion. Rummel G. Mendoza, D.C., P.C. v. Chubb Indemn. Ins. Co., 47 Misc.3d 156(A) 17 N.Y.S.3d 385 (Table)(App. Term 1 Dept. 2015). Where the insurer presents sufficient evidence to establish a defense based on a lack of medical necessity, the burden then shifts to the provider who must then present its own evidence of medical necessity. A Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co., 16 Misc. 3d 131(A), 841 N.Y.S.2d 824 (Table)(App. Term, 2d and 11 Jud. Dists. th 2007); West Tremont Med. Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 824 N.Y.S. 2d 759 (App. Term, 2d and 11 Jud. Dists. 2006).

Dr. Walsh submitted his IME findings in a report dated 6/28/19. He listed various medical records reviewed in connection with the examination. Specifically, he listed that on 12/21/18, FS underwent an open reduction and internal fixation for the left clavicle fracture. There were plates and screws placed in the bone to hold it in place. On 3/19/19, Dr. Walsh noted that an x-ray report showed that the left clavicle fracture had healed.

On examination, Dr. Walsh found:

Shoulders: There is an incisional scar over the anterior aspect of the left clavicle. There is no tenderness over the clavicle. Deformity - negative. Tenderness supraspinatus or acromioclavicular joint - negative. Crepitation - negative. Swelling - negative. Erythema

- negative. Instability Re: Faigy Siegel June 28, 2019 Page 6 (apprehension test) - negative. Bilateral shoulder range of motion: Flexion 180/180 degrees, extension 40/40 degrees, abduction 180/180 degrees, adduction 30/30 degrees, external rotation 90/90 degrees and internal rotation 80/80 degrees.

Pain on motion - negative. Neer test - negative. Cross-arm adduction test - negative. Ranges of motion were obtained using a goniometer. Standard ranges of motion were obtained from AMA - Guides to the Evaluation of Permanent Impairment, Fifth Edition.

DIAGNOSIS: Left clavicle fracture status post internal fixation, healed.

TREATMENT/OPINION: On examination, no objective clinical findings correlate with the reported imaging/diagnostic studies or the claimant's subjective complaints. Therefore, there is no need for treatment, follow-up, surgery, diagnostic testing, physical therapy, massage therapy, household help, medical supplies, or transportation from an orthopedic standpoint. She may continue her student activities.

The Applicant argued that this IME report is woefully deficient and that Dr. Walsh failed to consider the other injuries that FS sustained in the accident. Furthermore, Dr. Walsh failed to discuss that this 16-year-old child had a displaced mid-stem clavicle fracture with a 2 cm shortening. The fact that she underwent an ORIF necessarily included the possibility that she might need the plates and other hardware removed. Dr. Walsh completely ignored this issue in his IME report when he decided to terminate further treatment. He rejected the import of FS's shoulder pain. The removal of the hardware was the basis of this surgery, and FS complained about this pain to the treating physicians regularly over the year and a half after having surgery.

Dr. Walsh failed to consider the medical sequella that stems after having an ORIF procedure. Moreover, he failed to examine the jaw, nose, and back, all injured in the accident, and for which FS received physical therapy. The Applicant also pointed to the fact that on June 15, 2019, FS returned to the original surgeon complaining that she still had shoulder discomfort and had an MRI of her jaw for the pain sustained from the accident. The physician advised that FS could have the hardware removed in a year if the pain persisted. A few months later, the medical records showed that the patient returned with continuing complaints of pain in the shoulder near the fracture site.

I agree with the Applicant. Dr. Walsh's IME failed to examine the other orthopedic issues that this child sustained and was treated for following the accident. FS was hit by a car and injured her nose, jaw, and back. She was treated for these injuries, but Dr. Walsh failed to examine and discuss these injuries in his report. As for the clavicle fracture, the doctor failed to include an intelligent and professional analysis of the sequelae that exists when a 16-year-old undergoes an ORIF. These issues were spelled out by the surgeons in the reports created when the patient first had surgery. There are multiple contemporaneous medical reports where FS complained of pain in her clavicle, and the doctors discussed the possibility that the plates and screws might need to be removed. That scenario is precisely what occurred here. FS returned for this surgery on 8/26/20 and had the plates and screws removed.

Fee Schedule Defense

An insurer adequately preserves its fee schedule defense by checking Box 18 on the NF-10 denial of claim form to assert that fees were not in accordance with fee schedule. Matter of Global Liberty Ins. Co. v. Therapeutic Physical Therapy, P.C., 148 A.D.3d 502 (1st Dept. 2017). As provided in 11 NYCRR §65-3.8(g)(1)(ii), and recently affirmed by the court in 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), a fee schedule defense need not be preserved in a timely denial. Though it is a defense that can be raised at any time, it is still a defense, upon which the insurer bears the burden of proof. To that extent, where an insurer sets forth a defense based upon fee schedule they are required to come forward with competent evidentiary proof to support its fee schedule defenses. 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). When an insurer fails to demonstrate by competent evidentiary proof that a medical provider's claims were in excess of the appropriate fee schedules, their defense of noncompliance with the appropriate fee schedules cannot be sustained. 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. Tm, 1st Dep't, per curiam, 2006). Once the insurer makes a prima facie showing that the amounts charged by a provider were in excess of the fee schedule, the burden shifts to the provider to show that the charges involved a different interpretation of such schedule or an inadvertent miscalculation or error. Cornell Medical, P.C. v. Mercury Casualty Co., Misc. 3d 58, 884 N.Y.S.3d 558 (App. Term 2d, 11 & 13 Dists. 2009).

The Insurer submitted a document entitled a Reimbursement Worksheet which states that it calculates the facility fees using the EAPG. The calculation arrives at \$2882.35. The Applicant countered with a proposed EAPG amount of \$2916.31, supported by evidence. The name of the individual who prepared the Respondent's fee schedule worksheet is not identified, and there is no evidence that someone with expertise in fee schedule or EAPG issues prepared it. The Applicant's expert arrived at the amount of \$ 2916.31. I find the Applicant's proposed fee schedule amount persuasive and is the correct amount owed.

Accordingly, the applicant is awarded \$2916.31 in full satisfaction of this claim.

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
	Lenox Hill Hospital (NSUH)	08/26/20 - 08/26/20	\$14,550.37	Awarded: \$2,916.31
Total			\$14,550.37	Awarded: \$2,916.31

B. The insurer shall also compute and pay the applicant interest set forth below. 03/18/2021 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 have 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

1. Since this case 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 Nassau

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

01/31/2023
(Dated)

Phyllis Saxe

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:
b2321f9e2e124e396d32d0aba7d95397

Electronically Signed

Your name: Phyllis Saxe
Signed on: 01/31/2023