American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Rockaways ASC Development LLC d/b/a ASC of Rockaway Beach (Applicant)	AAA Case No.	17-22-1265-8450
	Applicant's File No.	123770
	Insurer's Claim File No.	653799
- and -	NAIC No.	Self-Insured
MVAIC (Respondent)		

ARBITRATION AWARD

I, Sandra Adelson, 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: the patient

1. Hearing(s) held on 05/11/2023
   Declared closed by the arbitrator on 05/11/2023

   John Faris, Esq. from Law Offices of Eitan Dagan (Woodhaven) participated virtually for the Applicant

   Tracy Bader Pollak, ESq. from Marshall & Marshall, Esqs. participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$11,420.87**, 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 was a 44 year old female who was injured in a motor vehicle accident which took place on 5/12/21. As a result of the accident, the patient sustained injuries including to the right shoulder. The patient came under the care of medical professionals and on 11/6/21, the patient underwent right shoulder surgery. Applicant seeks payment for the facility fee related to the surgery in issue.

   The respondent alleges that additional verification remains outstanding and that the claim is premature.

4. Findings, Conclusions, and Basis Therefor

The record consisted of claimant's submission, respondent's submission, as well as documents not enumerated within this decision but which are contained in the case file maintained by the American Arbitration Association. THE ARBITRATOR SHALL BE THE JUDGE OF THE RELEVANCE AND MATERIALITY OF THE EVIDENCE OFFERED pursuant to 11 NYCRR 65-4.5 (o) (1) (Regulation 68-D). The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations. Based on a review of the documentary evidence, this claim is decided as follows:

The respondent submitted additional verification requests dated 1/21/22 and 2/24/22. Respondent did not submit cogent proof of mailing of these two additional verification requests. However, applicant's submission included copies of these two letters and therefore applicant's submissioestablished receipt of both additional verification requests. The verification requests dated 1/21/22 and 2/24/22 both requested the same information and stated the respondent required the following:

"Complete hospital records, including all Emergency Department records/reports, Admission, Discharge and any applicable Radiological reports. This information is also being requested through Jamaica Hospital at 8900 Van Wyck Expressway, Jamaica, NY 11418-2897. If you do not have the requested information in your possession, please contact Jamaica Hospital to obtain it and satisfy this request."

Applicant responded to the request dated 1/21/22 by applicant's response letter dated 1/28/22 which stated that "This is in response to your verification request dated: 1/21/2022 -As an ambulatory surgical center, ASC of Rockaway is not in possession of the hospital records, please request directly from Jamaica Hospital."

Applicant's submission established that respondent's additional verification request dated 2/24/22 was not received by applicant until 3/9/22. On 3/12/22, the applicant again advised respondent that "This is in response to your verification request dated: 2/24/22

1. ASC of Rockaway Beach is not in possession of the hospital records or ER records. Please request directly from appropriate provider. Please note that you are requesting these items, it is not our responsibility to get those items. As a surgery center we do not have possession of the hospital records."

On 5/25/22, applicant again wrote to respondent that "This is in response to your written correspondence dated 2/24/22. The last correspondence we received from you was on 2/24/22 which was a verification request asking us to provide (mri, narrative etc). We responded with a letter dated 3/12/22 and we have had no other correspondence since.

We have tried multiple times to reach someone in your company to check status of this claim to no avail. If we do not receive any type of payment or denial within 45 days of this letter we will proceed with arbitration.

Please be advised that we have provided all requested items that you seek that are in our possession. We have exhausted all efforts to obtain the documents/information you are seeking. Your continued correspondence seeking the same information previously sought is improper.

In discovery, Courts have held that a party should not be required to comply with improper and overly broad demands. Abbadessa v. Sprint, 291 a.d.2D 363, 736 n.y.s.2D 880 (2nd Dept., 2002) The burden of serving a proper discovery demand rests with counsel, and it is not for the courts to correct a palpably bad one. Where demands are improper, overbroad, lack specificity or seek irrelevant information, the appropriate remedy is to vacate the entire demand rather than to prune it. Bell v. Cobble Hill Health Center, Inc., 22 A.D.3d 620, 804 N.Y.S.2d 362 (2nd Dept., 2006).

Here, the Defendant is seeking verification, a platform that is non-adversarial compared to discovery, and as such, Defendant's continued requests should be held to a standard that is even more narrowly tailored than discovery. Accordingly, we object to the continued verification requests as improper as they were already addressed.

We have stated we are not in possession of the sought documents. To the extent that such documents exist, please request this document along with any other requests from the appropriate medical providers. Additionally, provide proof of showing that the document was timely requested.

For any verification that has not been provided, we object to the information demanded as unduly burdensome and improper…." Therefore applicant preserved its objection to the aforesaid requests.

On 6/6/22 and 3/20/22, the respondent repeated the same verification requests and ignored the fact that applicant was not in possession of the records as it was an ambulatory surgery center. Respondent's actions in processing this claim ignored good claims practice principles, in that respondent treated this applicant as an adversary and failed to even respond to applicant's responses dated 1/28/22 and 3/12/22. Respondent essentially ignored the fact that the applicant advised them they did not have records and repeated the same request without advising applicant that they had received applicant's response. Applicant is not required to obtain records not in its possession.

Furthermore, the fact that respondent states it CC'd Jamaica Hospital on the requests is non-persuasive due to the fact there is no credible proof that anything was mailed to Jamaica Hospital. Furthermore, if respondent relies on letters addressed to applicant surgery center and not Jamaica Hospital, without an authorization from the patient to the hospital, respondent is simply delaying this claim because no hospital would just hand out records to an insurance company without an authorization and payment for said

records. This is especially important to note since respondent failed to request a HIPAA compliant authorization form applicant.

This arbitrator does not believe a hospital would process a verification request which was addressed to an ambulatory surgery center for the ambulatory surgery center's medical records. This situation is confusing and respondent's attempt to state that it tried to get records by CC'ing a request to Jamaica Hospital is not convincing.

Furthermore, there is no proof that

1) any letter from respondent was "CC'd" to the Jamaica Hospital or

2) any letters addressed to Jamaica Hospital

were actually mailed by respondent with an accompanying authorization from the patient addressed to the Medical Records Department. Therefore, the credible proof does not establish that any of respondent's letters dated 12/7/21 and 1/20/22 [which were addressed directly to Jamaica Hospital had been mailed. In short, there was no credible proof of mailing for these letters.

Additionally, the affidavit of respondent's claims representative, Silviya Gandrabo, was self- serving and conclusory. There was no credible proof of mailing of any letters and she even failed state who mailed to the letters allegedly addressed to Jamaica Hospital. Her affidavit was nothing more than a general review of the file without any specific information. She referred to workers in the mail room but failed to provide cogent information which would establish mailing of the letters addressed to Jamaica Hospital.

Commonsense would clearly establish that Jamaica Hospital would have respond with a statement that an authorization from the patient was needed with payment. Therefore, I find that respondent's reliance on a general and self-serving affidavit failed to support respondent's position. The wording of this affidavit was extremely non-specific and failed to credibly show that anything was mailed to Jamaica Hospital. The affidavit offers a general description of mailing of documents. Therefore I find that there was insufficient evidence to presume mailing based solely on the existence of a general assertion that there were mailing procedures in place during the relevant time. This affidavit was not credible and was self-serving.

Although Rettner v. CM Life Ins. Co., Inc., 2014 NY Slip Op 30273(U) involves the cancellation of a life insurance policy, the Court's discussion as to acceptable proof of mailing is applicable to the case at bar: "Moreover, CM's reply submissions do not satisfy the essential element of mailing. "While [Hastings'] affidavit . . . has established the manner in which ... notices were generated, printed, reviewed, forwarded to the mail room, assembled in the mail room, enveloped and posted, she has failed to establishtheir

mailing. . . 'Mailing is the deposit of a paper enclosed in a first-class postpaidwrapper [duly addressed]. . . in a post office or official depository under the exclusivecare and custody of the United States Postal Service within the State' (Zwelsky v NorthAmerican Company for Life and Health Insurance of New York, n.o.r., 2011 N.Y. Misc.LEXIS 2765, 2011 WL 2447587 [Sup Ct, NY Co, 2011] [internal citation omitted]).Hastings stated that the trays of sorted notices were left in a Mass Mutual facility untilthe Post Office sent someone to pick them up. In contrast, Stebbins averred that thenotices were driven to the Post Office. Neither affiant states that the notices wereactually mailed and CM has not furnished the affidavit of a postal worker stating that thenotices were regularly picked up or accepted by postal employees. Since CM's evidenceestablish[es] that the various notices were generated by defendant's computer system ...[but not] that the notices were actually mailed to [plaintiff, CM] fails to establish thepresumption that the notices generated were in fact delivered to [plaintiff], and as such,the delivery of the notices remains a genuine issue of fact" (Maharan v Berkshire LifeInsurance Co., 110 F Supp 2d 217, 221 [WDNY 2000], citing Caprino v NationwideMutual Insurance Co., supra, 34 AD2d 522). "[W]here cancellation or surrender of thepolicy is an issue, it is the province of the court to determine all questions of law, andquestions of fact ordinarily are to be determined by the jury. Thus, whether an insurancepolicy provision has been cancelled is a question of fact for the jury, where the party toreceive the notice denies that it was ever delivered" and the insurer has not establishedits entitlement to the presumption of receipt as a matter of law (45 C.J.S. Insurance §825)."

Therefore I find that the credible evidence established that respondent failed to establish mailing of the request to Jamaica Hospital or any letter alleged to have been "CC'd" to the hospital.

Additionally, Quality Psychological Servs. P.C. v. Hartford Ins. Co, 2013 NY Slip Op 50045 (U) is controlling: "The presumption of receipt may be created by either proof of actual mailing or proof of standard office practice or procedure designed to ensure that items are properly addressed and mailed. Residential Holding Corp. v. Scottsdale Ins. Co., 286 AD2d 679, 729 NYS2d 776 (2001); Nassau Ins Co. v. Murray, 46 NY2d 828,414 NYS2d 117 (1978); Matter of Francis v. Wing, 263 AD2d 432, 694 NYS2d 29 (NYA.D. 1st Dept., 1999); Azriliant v. Eagle Chase Assoc., 213 AD2d 573, 575, 624 NYS2d 238 (NY AD2d Dept., 1995); Phoenix Ins. Co v. Tasch, 306 AD2d 288, 762 NYS2d 99 (NY AD2d Dept., 2003); Matter of Colyar, 129 AD2d 946, 947, 515 NYS2d 330 (NY AD3d Dept., 1987). Therefore, affidavits that merely state that the bills were mailed within the statutory time period have been held insufficient to establish proof of actual mailing. Comprehensive Medical v. Lumbermens Mutual Ins. Co., 4 Misc 3d 133(A) (App. Term 9 & 10th Jud. Dists, 2004). The Appellate Term, Second Department's holding in Daras V. Geico Insurance Company (decided March 10, 2009), 22 Misc 3d 141(A), 2009 NY Slip Opinion 50438(U) required a respondent to establish by proof in admissible form that the IME requests were timely mailed to the patient and that the assignor failed to appear: "While defendant asserts that it timely denied plaintiff's claim based on the assignor's failure to appear for two scheduled IMEs, defendant failed to establish by proof in admissible form that the IME requests were timely mailed to the assignor and that the assignor failed to appear for the IMEs (see

Stephen Fogel Psychological, P.C. v Progressive Cas. Ins. Co., 35 AD3d 720 [2006]). Consequently, plaintiff's motion for summary judgment should have been granted. We reach no other issue."

Upon a review of the evidence submitted to the record, I find that the applicant provided information responsive to each request made by respondent. The applicant made it clear to respondent repeatedly that applicant medical provider was not in possession of reports, treatment notes, records of treatment or any reports other than those provided.

A party cannot provide or give documents or evidence not in its possession.

Therefore, D & R Med. Supply v. Progressive Ins. Co., 2009 NY Slip Op 29139, Decided March 31, 2009, Civil Court of the City of New York, Kings County is controlling to the facts presented by the applicant's responses to respondent's additional verification request. In short, this case stands for the proposition that a party or medical provider is not required to provide materials over which it had not control:

"The facts are essentially undisputed. Plaintiff D & R Medical Supply is a provider of medical equipment….

By letter dated July 23, 2007, defendant acknowledged receipt of the first claim. In the letter defendant stated as follows: "[a] report from the referring physician is required with comment regarding the medical necessity of the medical equipment."

Plaintiff responded to defendant's letter by its own letter, dated July 26, 2007, stating:

"We are in receipt of your letter dated July 23rd, 2007. Unfortunately D &R Medical Supply, Inc. is unable to provide you with referring physician report and/or any medical records that you are requesting for the above named patient. This type of documentation is not in our possession. We are medical supply company and provide supplies in accordance to the doctor's prescription. Please request it directly from the medical provider."

Defendant mailed a second copy of its July 23, 2007 letter to the plaintiff on August 24, 2007.

By letter dated August 11, 2007, defendant acknowledged receipt of the second claim and again stated that "[a] report from the referring physician is required with comment regarding [***] the medical necessity of the medical equipment." Plaintiff again informed defendant that it did not have such a report in its possession. On September 13, 2007, defendant mailed a second copy of its August 11, 2007 letter to the plaintiff.

To date, plaintiff has not provided the defendant with a report from any physician attesting to the medical necessity of the equipment at issue; for its part, defendant neither paid nor denied the claims at issue.

On its motion for summary judgment, plaintiff's position is that it submitted its bills to the defendant who neither paid nor denied the claims pursuant to the No-Fault Law and regulations. In defense, and on its own cross motion, it is defendant's position that the action on these claims is premature and must be dismissed. According to the defendant, the 30-day period within which it had to pay or deny the claims had not begun to run, inasmuch as plaintiff has yet to provide defendant with the reports of the referring physicians that had been timely requested as additional verification for each of the claims.

Analysis

Plaintiff established its prima facie entitlement to summary judgment by proving the submission of statutory claim forms, setting forth the fact and the amount of the loss sustained, and that payment of no-fault benefits was overdue (see Insurance Law § 5106 [a]; Mary Immaculate Hosp. v Allstate Ins. Co., 5 AD3d 742, 774 NYS2d 564 [2d Dept 2004]). The court notes that the affidavit submitted by plaintiff's billing manager demonstrated that the annexed claim forms constituted evidence in admissible form (see CPLR 4518; Dan Med., P.C. v New York Cent. Mut. Fire Ins. Co., 14 Misc 3d 44, 829 NYS2d 404 [App Term, 2d Dept 2006]). The burden thus shifted to defendant to raise a triable issue of fact (see Alvarez v Prospect Hosp., 68 NY2d 320, 324, 501 NE2d 572, 508 NYS2d 923 [1986]). Defendant failed to meet this burden.

There is no merit to defendant's argument that the statutory time period within which it had to pay or deny the claim was tolled due to plaintiff's failure to provide it with the materials it had requested as additional verification of the claims. Assuming that the letters sent to plaintiff by defendant constituted valid initial and follow-up demands for additional verification of the claims, plaintiff unequivocally advised defendant that it was not in possession of the medical reports that defendant was seeking. Certainly, there is no evidence before the court suggesting that these materials were ever in plaintiff's care, custody or control.

Even under the liberal discovery provisions embodied in article 31 of the CPLR, a party to a lawsuit is required to produce only those items "which are in the possession, custody or control of the party" (CPLR 3120 [1] [i]; see generally Saferstein v Stark, 171 AD2d 856, 568 NYS2d 27 [2d Dept 1991]; Corriel v Volkswagen of Am., 127 AD2d 729, 730, 512 NYS2d 126 [2d Dept 1987]; Lear v New York Helicopter Corp., 190 AD2d 7, 11, 597 NYS2d 411 [2d Dept 1993]). While the no-fault regulations provide that an "insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom such verification was requested" (11 NYCRR 65-3.5 [c], this should not be construed as requiring a provider to provide materials over which it has no control. A contrary construction would violate the core objective of the No-Fault Law: "to assure claimants of expeditious compensation for their injuries through prompt payment of first-party benefits without regard to fault and without expense to them" (Dermatossian v New York City Tr. Auth., 67 NY2d 219, 225, 492 NE2d 1200, 501 NYS2d 784 [1986]) and would frustrate one of the main purposes of the regulatory scheme, which is "to provide a tightly timed process of claim, disputation

and payment" (Presbyterian Hosp. in City of N.Y. v Maryland Cas. Co., 90 NY2d 274, 281, 683 NE2d 1, 660 NYS2d 536 [1997]; see also New York Hosp. Med. Ctr. of Queens v Motor Veh. Acc. Indem. Corp., 12 AD3d 429, 430, 784 NYS2d 593 [2d Dept, 2004]). Imposing upon a medical provider the obligation to provide an insurer with materials that are not in its care, custody or control would also be illogical…"

Therefore, it is clear that D & R, supra establishes that there is no merit to defendant's argument that the statutory time period within which it had to pay or deny the claim was tolled due to plaintiff's failure to provide it with the materials it had requested as additional verification of the claims. Assuming that the letters sent to plaintiff by defendant constituted valid initial and follow-up demands for additional verification of the claims, plaintiff unequivocally advised defendant that it was not in possession of the medical reports that defendant was seeking. Certainly, there is no evidence suggesting that these materials were ever in plaintiff's care, custody or control. Additionally, the applicant was required to produce only those items "which are in the possession, custody or control of the party" (CPLR 3120 [1] [i]).

Furthermore, I also find that respondent did not provide responsive answers to the applicant upon the submission of each response to the verification requests. All Health Med. Care v. Government Empls. Ins. Co., 2004 NY Slip Op 24008, 2 Misc. 3d 907, Civil Court of the City of New York, Queens County stands for the proposition that once plaintiff submitted a response, defendant had a duty to pay, deny or request further verification. Since defendant failed to act, it is precluded from presenting any defenses to plaintiff's claim .

Additionally, as noted by the court in D & R, supra. the respondent essentially violated the core objective of the No-Fault Law: "to assure claimants of expeditious compensation for their injuries through prompt payment of first-party benefits without regard to fault and without expense to them" (Dermatossian v New York City Tr. Auth., 67 NY2d 219, 225, 492 NE2d 1200, 501 NYS2d 784 [1986]) and would frustrate one of the main purposes of the regulatory scheme, which is "to provide a tightly timed process of claim, disputation and payment.

Applicant advised respondent that it was not in possession of the records. Respondent failed to show that it had actually mailed any requests to Jamaica Hospital. Respondent also failed to explain why it needed records from the emergency room after the accident due to the fact that the applicant was seeking payment six months later for shoulder surgery which was necessitated as a result of the accident of 5/12/21. I therefore find that applicant complied with the additional verification requests. Respondent has not established that it delayed the claim by mailing requests to Jamaica Hospital. The record failed to include persuasive and credible evidence of anything being mailed to Jamaica Hospital by respondent.. The affidavit submitted by respondent failed to establish the foregoing. Therefore the claim for the facility fee is overdue. In short, the claim is not premature as applicant complied responsively to the verification requests.

Fee Schedule Defense:

Applicant relied on its 3M printout as evidence of its claim. However, I find that the coder affidavit from Dr. James Lee, D.C., CPC established that applicant did not correctly bill this claim. Dr. Lee noted that

"Per the Medicare National Correct Coding Initiative (NCCI), modifier 59 is used "to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances." The use of modifier 59 must be supported by documentation demonstrating a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same individual." However, "when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

Further, on page 7, example 6, it explains that modifier 59 should not be used when multiple surgical arthroscopy procedures are performed on the same shoulder during the same operative session. This is the exact same situation in this claim. As such, modifier 59 cannot be used.

CPT codes 29827 and 29821 correspond to APO group 38 for level II arthroscopy with an assigned APO weight of 18.9106. Modifier 59 is not appropriate as explained above. Only one code is reimbursable per APO group. As such, CPT code 29827 is reimbursable at 100% and CPT code 29821 is not separately reimbursable. Effective 03/15/21, CPT code 29827 falls under a group of services that are reimbursable at set rates. However, it is limited to $5,677.77 as billed.

CPT codes 29825 and 29826 correspond to APO group 37 for level I arthroscopy with an assigned APO weight of 9.9509. Modifier 59 is not appropriate as explained above. APO consolidation logic states that APO group 37 is consolidated into APO group 38. As such, these codes are not separately reimbursable.

The claim totaling $11,420.87 exceeds the permissible fee schedule. The correct allowable amount is $5,677.77."

Upon a review and comparison of the 3M printout with the explanation offered by Dr. Lee, I find that his analysis was detailed, informative and thorough. This coder report disproved applicant's fee schedule amount. Additionally, the applicant did not submit a coder report to refute Dr. Lee's coder analysis.

The claim is, accordingly. granted for $5,677.77.

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**
	Rockaways ASC Development LLC d/b/a ASC of Rockaway Beach	**11/06/21 - 11/06/21**	**$11,420.87**	**Awarded: $5,677.77**
Total			**$11,420.87**	**Awarded: $5,677.77**

B. The insurer shall also compute and pay the applicant interest set forth below. 01/28/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant submitted a verification response dated 1/28/22 which advised respondent it did not possess the requested documents. Therefore interest is to run from 30 days from the presentment of the verification response and allowing five days for mailing of said verification response.

C. Attorney's Fees

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

Applicable attorney fees on the amount awarded in accordance with 11 NYCRR 65-4.6(d).

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 NY
SS :
County of Suffolk

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

06/07/2023
(Dated)

Sandra Adelson

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:
3939949f0d41d8a5090dcc63e8d18d5f

Electronically Signed

Your name: Sandra Adelson
Signed on: 06/07/2023