American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

New York Medical Monitoring PC (Applicant)	AAA Case No.	17-22-1263-4348
	Applicant's File No.	n/a
- and -	Insurer's Claim File No.	21-4163972
	NAIC No.	24279
Progressive Casualty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Heidi Obiajulu, 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: Injured Party

1. Hearing(s) held on 06/12/2023
   Declared closed by the arbitrator on 06/12/2023

   Dino R. DiRienzo, Esq. from Dino R. DiRienzo Esq. participated virtually for the Applicant

   Regina Wilcox from Progressive Casualty Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$17,259.69**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The applicant amended its claim to $3227.25 to the amount left on the PIP policy.

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

3. Summary of Issues in Dispute

   The applicant seeks reimbursement of charges for continuous intraoperative neurophysiology monitoring [BR CPT code 95941] and SSEPs [CPT code 95938] performed on 10/27/21, following a motor vehicle accident occurring on 03/01/21. The respondent timely denied the claim based on the defense that the applicant failed to substantially comply with its verification requests sent on 11/11/21 and 12/16/21 [and

01/20/22, 02/07/22, and 02/21/22] within 120 calendar days from its initial verification request or provide written reasonable justification for its failure to comply.

4. Findings, Conclusions, and Basis Therefor

The below decision is based on the documents contained in the Electronic Case folder maintained by the American Arbitration Association (hereinafter referred to as AAA) as of the date of this hearing.

The applicant, as assignee of the Injured Party, seeks reimbursement, with interest and counsel fees, under the No-Fault Regulations, for continuous intraoperative neurophysiology monitoring [BR CPT code 95941] and SSEPs [CPT code 95938] performed on 10/27/21, in the amended amount of $3227.25.

The respondent insured the motor vehicle involved in the automobile accident. Under New York's Comprehensive Motor Vehicle Insurance Reparation Act (the "No-Fault Law"), New York Ins. Law §§ 5101 et seq., the respondent was obligated to reimburse the injured party (or its assignee) for all reasonable and necessary medical expenses arising from the use and operation of the insured vehicle.

This case arises out of a motor vehicle accident occurring on March 01, 2021, in which the Injured Party (SL), a then 31-year-old female sustained multiple injuries including to the neck, hip, and left ankle/foot while driving the insured vehicle when it collided with the adverse vehicle. After the accident, the Injured Party was taken to the emergency room of Stony Brook University Hospital where she was evaluated, treated, underwent radiological testing, and released.

Subsequently, the Injured Party commenced conservative care.

On 07/08/21, Dr. Angel Macagno, MD initially evaluated the Injured Party and recommended surgery to the spine.

On 10/27/21, Dr. Macagno performed a cervical-anterior cervical decompression fusion at C5-C6. The applicant performed the disputed SSEP and continuous intraoperative neurophysiology monitoring outside the operating room.

Thereafter, the applicant submitted its claim form to the respondent seeking reimbursement of its claim. The applicant billed in the amount of $4582.70 under the BR CPT code 94941 and $12,677.99 under CPT code 95938. At the arbitration, the applicant reduced its claim to $3227.25, the amount remaining on the PIP policy based on the respondent's submitted payment summary document.

The respondent submitted evidence to show that it received the applicant's claim on 10/29/21.

On 11/11/21, the respondent sent the applicant a verification request seeking to obtain information to support the BR billing for CPT code 95941. Specifically, the respondent sought, *"1) The relative value unit consistent in relativity with other relative value units shown in the Fee Schedule, and 2) Any pertinent information concerning the nature, extent, and need for the procedure or service, the skill, and equipment necessary."* The verification request contained the requisite notification language of 11 NYCRR section 65-3.5(o).

On or about 11/26/21 [per the affidavit of mailing by Faizan Kamran], the applicant responded to the respondent's verification requests. The applicant submitteda copy of the excerpt of the NYS Workers' Compensation Medical fee schedule listing the billed BR code 95941 with a notation that the code was billed according to the fee schedule because it did not have a relative value. The applicant also submitted a copy of the technical report corresponding to the disputed medical services that explain SSEPs and a copy of the intraoperative neurophysiology report.

On 12/16/21, the respondent sent a follow-up verification request to the applicant seeking the same information sought in the initial verification request. The verification request contained the requisite notification language of 11 NYCRR section 65-3.5(o).

On 01/20/22. The respondent sent a follow-up verification to the applicant acknowledging the applicant's response and requesting information to substantiate the RVU for the billed amount of $4582.70 for BR CPT code 95941. The verification request indicates that the respondent still sought, *"1) The relative value unit consistent in relativity with other relative value units shown in the Fee Schedule, and 2) Any pertinent information concerning the nature, extent, and need for the procedure or service, the skill, and equipment necessary."*

The respondent contends that it did not receive any response to its follow-up verification request sent on or about 01/20/22.

On 02/07/22, the respondent sent another follow-up verification request seeking the same information sought in the 01/20/22 verification request.

Finally, on 02/21/22, the respondent sent a follow-up verification request seeking the same information sought in the 02/07/22 verification request.

On 03/18/22, within 150 calendar days of its receipt of the applicant's claim form, the respondent denied reimbursement on the grounds that the applicant failed to comply with its verification requests within 120 calendar days of the initial verification request sent on 11/11/21 and/or provide written justification for its failure to respond.

After it received the respondent's denial, the applicant commenced this arbitration seeking reimbursement of its claim.

At the outset, I find that the applicant established its prima facie case with the submission of its claim form and the copy of the respondent's denial of claim form,

which demonstrates that the respondent received the applicant's claim form, that more than 30-days elapsed since its receipt of same, and that the respondent denied reimbursement of the applicant's claim, which shows that the applicant's claim is now due and owing. See Insurance Law section 5106 [a]; Viviane Etienne Medical Care, PC v. County-Wide Ins. Co 25 N.Y.3d. 498, (NY, June 10, 2015), Westchester Medical Center v. Nationwide Mut. Ins. Co., 78 A.D.3d. 1168, (N.Y.A.D. 2nd Dept., November 30, 2010).

Once an applicant establishes a prima facie case, the burden then shifts to the insurer to prove its defense.

However, even before determining whether the respondent met its burden of proof, it must first be determined whether the respondent's defense survives preclusion.

I find that the respondent's 120-day defense is preserved based on the uncontested timely and legally sufficient denial asserting that defense.

Therefore, the issue is whether the respondent met its burden of proof in establishing its defense.

The respondent's hearing representative argued that the respondent met its burden of proof in establishing that the respondent failed to substantially comply with the respondent's verification requests within 120 calendar days from the initial verification request sent on 11/11/21 or provide written reasonable justification for the failed response with its arbitration submissions. Therefore, she argued that the respondent's denial should be sustained.

The applicant's attorney argued that it substantially complied with the respondent's verification requests when it submitted the documentation on or about 11/26/21. He contended that the respondent's verification requests did not ask specific questions regarding the expertise of the provider performing the medical services billed under CPT code 95941. Alternatively, he argued that, at the very least, the respondent should have reimbursed the applicant for the SSEPs, billed under CPT code 95938, because the verification requests pertained solely to CPT code 95941. He contended that CPT code 99358 has an established reimbursement rate. Regarding the respondent's fee schedule reduction defense and EOB regarding CPT code 99538, he rested on the record.

Reviewing the relevant evidence in the record and considering the oral arguments made by the parties, I find as follows:

11 NYCRR section 65-3.5(o) provides: "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 an accident occurring on or after April 1, 2013."

11NYCRR section 65-3.8(b) (3) provides:

"Except as provided in subdivision (e) of this section, an insurer shall not issue a denial of claim form (NYS Form N-F 10) prior to its receipt of verification of all of the relevant information requested pursuant to sections 65-3.5 and 65-3.6 of this Subpart (e.g., medical reports, wage verification, etc.). However, an insurer may issue a denial if, more than 120 calendar days after the initial request for verification, the applicant has not submitted all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply, provided that the verification request so advised the applicant as required in section 65-3.5(o) of this Subpart. 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 paragraph 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 an accident occurring on or after April 1, 2013."

Applying the above regulations to the evidence in the record, I find that the respondent established its 120-day defense regarding CPT code 95941 because based on my review of the documentation sent to the respondent by the applicant on or about 11/26/21, the applicant did not substantially comply with the respondent's verification requests. The applicant appears to have submitted a copy of the excerpt of the NYS Workers' Compensation Medical fee schedule listing the billed BR code with a notation that 95941 was billed according to the fee schedule because it did not have a relative value. The applicant also submitted a copy of the technical report corresponding to the disputed medical services that explain SSEPs and a copy of the intraoperative neurophysiology report. I find that the applicant's submitted documentation is not responsive to the respondent's verification requests which sought to obtain information needed to establish the billed RVU including " *Any pertinent information concerning the nature, extent, and need for the procedure or service, the skill, and equipment necessary."* Therefore, I find that the applicant did substantially comply with the respondent's verification requests regarding the BR CPT code 95941 within the requisite 120 calendar days from the initial verification request.

However, I am persuaded by the arguments of the applicant's attorney that the verification requests did not pertain to CPT code 95938 [SSEPs] and that the respondent did not assert any defense to support denying reimbursement of that code. However, I am relying on the respondent's fee reduction defense and EOB explaining the defense. Consequently, I find that the applicant is entitled to be reimbursed $683.79 as reimbursement of CPT code 95938.

Accordingly, for the above reasons, I find in favor of the applicant in the amount of $683.79 as reimbursement of CPT code 95938. I find in favor of the respondent regarding CPT code 95941.

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**	**Amount Amended**	**Status**
	New York Medical Monitoring PC	**10/27/21 - 10/27/21**	**$17,259.69**	**$3,227.25**	**Awarded: $683.79**
Total			**$17,259.69**		**Awarded: $683.79**

B. The insurer shall also compute and pay the applicant interest set forth below. 08/23/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant's award in the amount of $683.79 shall bear interest at a rate of two percent per month, calculated on a pro-rata basis using a 30-day month from 08/23/22, the date the applicant initiated this arbitration, to the date of the payment of the award, pursuant to 11 NYCRR 65-3.9 (a) and LMK Psychological Servs. P.C. v. State Farm Mut. Auto Ins. Co, 12 N.Y.3d 217, (N.Y., April 02, 2009) since Applicant did not commence this Arbitration proceeding within 30 days after receiving the subject denial(s).

C. Attorney's Fees

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

As this matter was filed **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 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 NJ
SS :
County of Union

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

06/12/2023
(Dated)

Heidi Obiajulu

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:
945b27c9ef500caad81f691eaf5204a2

Electronically Signed

Your name: Heidi Obiajulu
Signed on: 06/12/2023