

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

|  |                          |                  |
|--|--------------------------|------------------|
| Queens Arthroscopy & Sports Medicine PC<br>(Applicant) | AAA Case No.             | 17-23-1280-9170  |
|  | Applicant's File No.     | 156153           |
| - and -  | Insurer's Claim File No. | 8727278640000003 |
| Geico Insurance Company<br>(Respondent)                | NAIC No.                 | 22055            |

**ARBITRATION AWARD**

I, Neal S Dobshinsky, 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: J Doe

1. Hearing(s) held on 10/11/2023  
Declared closed by the arbitrator on 10/11/2023

Aleksy Selipanov from The Law Offices of John Gallagher, PLLC participated virtually for the Applicant

Christine DiGregorio from Rivkin & Radler LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$10,074.52**, 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

On 5/26/22, Insurer conducted the examination under oath of Laxmidhar Diwan, MD, a physician with and owner of Applicant. Insurer followed the EUO with written post-EUO requests for additional verification of claims. Insurer contends that Applicant did not adequately respond to the post-EUO requests for additional verification and certain items remain outstanding.

On 8/22/22, Diwan saw J Doe at an office visit and on the same day Diwan performed arthroscopic surgery on Doe's right shoulder. A physician assistant with Applicant assisted at the surgery. Applicant sought payment of the physician's and the assistant's fees.

On 10/5/22, Insurer acknowledged receipt of Applicant's claims for the 8/22/22 services. Insurer referenced the 5/26/22 EUO and reiterated its post-EUO request for additional verification. Insurer contends that Applicant did not respond.

On 12/30/22, Applicant requested arbitration.

On 2/22/23, Insurer denied the claims in this matter. Insurer contends that Applicant did not provide the requested verification or written proof of a reasonable justification for the failure to provide it within 120 days from 10/5/22, the date of the initial request. Insurer asserted that the fees sought are excessive and not in accordance with the fee schedules.

Did Insurer establish its 120-day rule defense? Are the denials of claim effective? How much, if anything, is Applicant entitled to?

#### 4. Findings, Conclusions, and Basis Therefor

I have read and considered the materials in the AAA ADR case file. I have heard and considered the arguments of counsel. I find as follows:

##### **Background**

On 6/24/22, J Doe, then 53 years old, was the driver of a motor vehicle that was in an accident. The vehicle was insured for no-fault benefits by respondent Insurer. Doe claimed he was injured. Doe then sought care and treatment.

On 8/22/22, Doe saw Laxmidhar Diwan, MD, a physician with and owner of applicant Queens Arthroscopy & Sports Medicine for a follow-up evaluation. Doe continued to complain of right shoulder pain with difficulty in overhead activities and inability to lift heavy objects. Doe had not responded to a nonoperative course of management. MRI revealed rotator cuff tear supraspinatus/subscapularis/infraspinatus; labral tear; impingement; joint effusion; and synovitis.

Diwan examined Doe. The diagnoses were the same as the MRI findings. Diwan recommended diagnostic and arthroscopic surgery.

On the same day, 8/22/22, Diwan performed arthroscopic surgery on Doe's right shoulder including shaving and debridement of labral tear; synovectomy; bursectomy; subacromial lysis of adhesions; subacromial decompression and acromioplasty; repair of full thickness rotator cuff tear; and intraarticular injection of 0.25% Marcaine. Robert Yuen, PA, acted as the surgical assistant.

## **Applicant's Claims and Insurer's Response/Denial**

Applicant, as Doe's assignee, timely submitted three claims, all dated 9/13/22, to Insurer for no-fault benefits for payment for the services rendered on 8/22.

Applicant billed \$127.41 for the office visit with Diwan, CPT code 99214 25.

For Diwan's services at the arthroscopy, Applicant billed: \$2,348.08 for rotator cuff repair, code 29827; \$2,065.92 for shaving and debridement of the labral tear, code 29823-59; \$2,060.87 for lysis of adhesions, code 29825-59; \$1,957.57 for complete synovectomy, code 29821-51; \$496.32 for subacromial decompression and acromioplasty, code 29826; and \$62.99 for an intraarticular injection, code 20610.

For Yuen's services at the arthroscopy, Applicant billed for the same codes as it billed for Diwan's services with but addition of modifier 83, physician assistant as assistant surgeon. Yuen's services were billed at 10.7 percent of the listed values of the surgical codes.

On 5/26/22, Insurer had conducted the examination under oath of Diwan who testified on behalf of Applicant. Insurer followed the EUO with written post-EUO requests for additional verification of claims. Insurer contends that Applicant did not adequately respond to the post-EUO requests and that certain items remain outstanding.

On 10/5/22, Insurer separately acknowledged receipt of Applicant's claims for the 8/22/22 services. Insurer referenced the 5/26/22 EUO and reiterated its post-EUO request for additional verification. Insurer contends that Applicant did not respond.

On 12/30/22, Applicant requested arbitration.

On 2/22/23, Insurer denied the claims in this matter. Insurer contended that Applicant did not provide the requested verification or written proof of a reasonable justification for the failure to provide it within 120 days from 10/5/22, the date of the initial request. Insurer asserted that the fees sought are excessive and not in accordance with the fee schedules.

The only issues argued and submitted for determination were: Did Insurer establish its 120-day rule defense? Are the denials of claim effective? How much, if anything, is Applicant entitled to? All other issues were waived.

## **Claim Processing, Insurer's Requests for Additional Verification and the 120-Day Rule**

The regulations provide that "[w]ithin 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part." 11 NYCRR 65-3.8 (c). The 30-day period may be extended by the insurer's timely demand for further verification of the claim. 11 NYCRR 65-3.5 (b); 65-3.6 (b). Such demand must be made within 15 business days of receipt of the prescribed verification forms. 11

NYCRR 65-3.5 (b). If the demanded verification is not received within 30 days, the insurer must issue a follow-up request within 10 days of the insured's failure to respond. 11 NYCRR 65-3.6 (b). A claim need not be paid or denied until all demanded verification is provided. 11 NYCRR 65-3.8 (b) (3). No-fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which includes verification of all the relevant information requested pursuant to 11 NYCRR 65-3.5.

An insurer is entitled to request and receive information necessary to the processing and verifying of the applicant's claim (see 11 NYCRR 65-3.5 [c]), the scope of the requested materials is not unlimited (see generally 11 NYCRR 65-3.6 [b]). The regulations require the existence of "good reasons" to demand verification (see 11 NYCRR 65-3.2 [c]; *Doshi Diagnostic Imaging Servs. v State Farm Ins. Co.*, 16 Misc3d 42 [App Term, 2d Dept, 9th & 10th Jud Dists 2007]).

"[A]n 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" . . . . 11 NYCRR 65-3.8 (b) (3).

### **Service of Insurer's Requests for Additional Verification**

Insurer contends that it timely requested additional verification of the 8/22 claims from Applicant and that Applicant has not responded. Insurer contends its time to pay or deny the claims was tolled, and that Applicant's request for arbitration was premature. The matter is not ripe for arbitration.

Applicant contends that Insurer did not request additional verification in conformity with the regulations. Its requests are ineffective.

Unless an applicant admits receipt of the request-which Applicant does not do-the insurer must prove that the applicant received the request. Where the insurer contends that it mailed the request to applicant, the insurer must introduce sufficient competent evidence of mailing to raise the presumption of receipt.

Applicant's Arbitration Request Form (AR-1) dated 12/20/22, does not indicate that Applicant supplied any verification. Nothing in Applicant's submission alluded to any requests for additional verification or responses to such requests. Insurer was on notice that its requests for additional verification were at issue.

"Generally, proof of proper mailing gives rise to a presumption that the item was received by the addressee. The presumption may be created by either proof of actual mailing or proof of a standard office practice or procedure designed to ensure that items are properly addressed and mailed" (internal citations omitted). *Residential Holding Corp. v Scottsdale Ins. Co.*, 286 AD2d 679 [2d Dept 2001].

In support of its 120-rule violation defense, Insurer submits an affidavit by Adam Akiwowo, a claims supervisor with Insurer. In his 10/11/23 affidavit, Akiwowo states

that he has been employed by Insurer since 2016. He has knowledge of Geico's standard business practices regarding mailing and receiving PIP correspondence. He is familiar with the documents regarding these claims.

Akiwowo states that Insurer received the three claims on 9/19/22, and that by letters dated 10/5/22, Insurer requested additional verification, which was the same as its post-EUO verification requests. Copies of the 10/5/22 letters are in Insurer's submission. Akiwowo, does not specifically mention any other post-EUO requests for additional verification. Although Insurer's submission includes copies of second or follow-up requests for the additional verification, dated 11/11/22, there is no evidence that those requests were ever mailed to Applicant or anyone else. Merely because letters are in Insurer's file does not mean that they were ever mailed.

While Akiwowo's affidavit is sufficient to raise the presumption that the first, 10/5/22, requests for additional verification were mailed and therefor received by Applicant, there is no competent evidence to raise the presumption as to the second letters.

Without follow-up letters for additional verification as required, Insurer's 120-day rule defense has no merit.

### **When Arbitration May Be Initiated; Is This Claim Arbitrable**

"In the absence of a denial of claim form, a dispute shall be considered arbitrable if the claim is overdue . . . and a demonstrable attempt was made by the applicant to obtain payment or an explanation from the insurer of the continued nonpayment of the claim." "As a condition precedent to arbitration where there is no denial of claim by an insurer, evidence of attempts to settle the dispute must be detailed on the arbitration request form." 11 NYCRR 65-4.2 (b) (1) (v).

Despite Applicant's implicit assertion in its AR-1 that denials had been issued before it initiated arbitration, no denials were issued. The only denials Insurer issued for these claims were issued on 2/22/23, almost two months *after* Applicant initiated arbitration. These denials do not retroactively make the claims arbitrable, and their effect does not have to be decided in this arbitration.

Nevertheless, because the Insurer failed to show that it made proper requests for additional verification, which would have tolled its time to pay or deny Applicant's claims, there were no proper requests for verification outstanding at the time Applicant initiated arbitration. When Applicant filed for arbitration, payment on the claims was overdue.

### **How Much Is Applicant Entitled To?**

An insurer is only required to reimburse a claimant in accordance with the regulations and applicable fee schedule. 11 NYCRR 65-3.8 (g) (1) (ii). An insurer is not

even required to establish that it had timely denied the claim to preserve its fee schedule defense. *Oleg's Acupuncture, P.C. v Hereford Ins. Co.*, 58 Misc3d 151[A] [App Term, 2d Dept, 2d, 11th, & 13th Jud Dists 2018], 2018 NY Slip Op 50095(U).

No expert evidence (coder) is needed to determine what is plain in the regulations, fee schedule, and other authorities (CPT Book and CPT Assistant). *Matter of Global Liberty Ins. Co. v McMahon*, 172 AD3d 500, 501 [1st Dept 2019] (The CPT Assistant is incorporated by reference into the CPT book, which is incorporated by reference into the Official New York Workers' Compensation Medical Fee Schedule).

Applicant billed for the office visit with Diwan on 8/22/22 under code 99214-25. Applicant is not entitled to payment for that office visit. In accordance with the description of modifier 25, "[t]his modifier is not used to report an E/M service that resulted in a decision to perform surgery." New York State Workers' Compensation Medical Fee Schedule, Surgery Ground Rule 20, Modifiers. Furthermore, "[u]nder most circumstances . . . the immediate preoperative visit in the hospital or elsewhere necessary to examine the patient, complete the hospital records and initiate the treatment program is included in the listed value for the surgical procedure." Surgery Ground Rule 2, Immediate Preoperative Visits and Other Services.

Applicant billed for four procedures by adding modifier 59 to the codes. A common misuse of modifier 59 is related to "different procedures or surgeries." On one hand, "the two procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter." On the other hand, "if the two procedures/surgeries are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier 59 may be appended to indicate that they are different procedures/surgeries on that date of services. See, The National Correct Coding Initiative explains the correct use of modifier 59.

While separate incisions potentially qualify for the use of modifier 59, arthroscopy of structures in adjoining areas of the same shoulder constitutes treatment of a single anatomic site. Separate incisions are an inherent part of arthroscopic procedures. When the arthroscopy is performed on the same shoulder in the same session, it is not appropriate to use modifier 59.

For the surgery on 8/22/22, Surgery Ground Rule 5, Multiple or Bilateral Procedures, applies. Under Surgery GR5, "[w]hen multiple procedures, unrelated to the major procedure and adding significant time or complexity, as provided at the same operative session, payment is for the procedure with the highest allowance plus half of the lesser procedures."

Applicant billed under codes 29827, 29823, 29825, and 29821. Based on the fee schedule and Surgery GR 5, Applicant is entitled to \$2,348.08 for code 29827 the procedure with the highest allowance; plus \$1,032.96 (one-half of the amount billed for code 29823); plus \$1,030.44 (one-half of the amount billed for code 29825); plus \$978.79 (one-half of the amount billed for code 29821). Code 29826 is an add-on

procedure. It is exempt from the 50 percent reduction. Code 20610 is a separate procedure. Accordingly, Applicant is entitled to a total of \$5,949.58 for Diwan's services.

Modifier 83 provides that "[w]hen a physician assistant . . . performs the services for assistants at surgery . . . [those [s]ervices are reimbursed at 10.7 percent of the listed value of the surgical code and payable to the employing physician." Surgery GR 20, Modifiers. The fees for Yuen's services are thus limited. Applicant is entitled to \$636.61 for his services.

## Conclusion

Insurer failed to establish its 120-day rule defense. However, the fees sought by Applicant are excessive and not in accordance with the fee schedule.

Based on the parties' submissions, their arguments, the law, the regulations, and the weight of the credible evidence, I conclude that Applicant is entitled to payment in accordance with the foregoing.

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 |
|---------|----------------------|------------|--------------|--------|
|         | Queens Arthroscopy & | 08/22/22 - |              |        |

|              |  |                                |                         |                                |
|--------------|--|--------------------------------|-------------------------|--------------------------------|
|              | <b>Sports<br/>Medicine PC</b>                                  | <b>08/22/22</b>                | <b>\$127.41</b>         | <b>Denied</b>                  |
|              | <b>Queens<br/>Arthroscopy &amp;<br/>Sports<br/>Medicine PC</b> | <b>08/22/22 -<br/>08/22/22</b> | <b>\$8,991.74</b>       | <b>Awarded:<br/>\$5,949.58</b> |
|              | <b>Queens<br/>Arthroscopy &amp;<br/>Sports<br/>Medicine PC</b> | <b>08/22/22 -<br/>08/22/22</b> | <b>\$955.37</b>         | <b>Awarded:<br/>\$636.61</b>   |
| <b>Total</b> |  |                                | <b>\$10,074.5<br/>2</b> | <b>Awarded:<br/>\$6,586.19</b> |

- B. The insurer shall also compute and pay the applicant interest set forth below. 12/30/2022 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Insurer shall compute and pay interest from the accrual date noted above-the date on which Applicant requested arbitration by filing with the AAA-at a rate of 2% per month, simple interest, calculated on a pro-rata basis using a 30-day month and ending with the date of payment subject to the provisions of 11 NYCRR 65-3.9.

C. Attorney's Fees

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

Insurer shall pay Applicant's attorney a fee in an amount equal to 20% of the total amount of the benefits plus interest awarded in this arbitration, subject to the provisions of 11 NYCRR 65-4.6.

- 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 NJ

SS :

County of Monmouth



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

11/05/2023  
(Dated)

Neal S Dobshinsky

### **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:**  
ff1c2caa46c05f7a08035825a46a30f2

### Electronically Signed

Your name: Neal S Dobshinsky  
Signed on: 11/05/2023