

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Global Surgery Center LLC
(Applicant)

- and -

Avis Budget Group
(Respondent)

AAA Case No. 17-23-1287-3302

Applicant's File No. 173.891

Insurer's Claim File No. 228027965-009

NAIC No. Self-Insured

ARBITRATION AWARD

I, Marcelo Vera, 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 10/18/2023
Declared closed by the arbitrator on 10/18/2023

Vincent Ku, Esq. from Tsirelman Law Firm PLLC participated virtually for the Applicant

Lochlan McDonell, Esq. from Rubin, Fiorella, Friedman & Mercante LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$10,095.09**, 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 arbitration arises out of treatment to the EIP, SB, a female, involved in a motor vehicle accident on August 07, 2022. Applicant seeks reimbursement in the amount of \$10,095.09 representing the facility fees associated with a right shoulder arthroscopy surgery performed October 13, 2022. Respondent has issued a denial based on the peer review prepared by Ronald Mann, M.D. dated December 16, 2022. Further the denial states the fees as billed are above fee schedule. Respondent's counsel notes the proper fee schedule for the facility fee would be \$3,026.24 based upon the Fee schedule affidavit prepared by Beth Siedman, CPC dated April 17, 2023.

4. Findings, Conclusions, and Basis Therefor

My decision is based on the arguments of representatives for each party as well as those documents contained in the electronic file maintained by the American Arbitration Association. I have reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

It is Applicant's *prima facie* obligation to establish its entitlement to payment for each service for which reimbursement is sought. It is well settled that a health care provider establishes its *prima facie* entitlement to payment as a matter of law by proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see *Insurance Law § 5106 a*; *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]; *Amaze Med. Supply v. Eagle Ins. Co.*, 2 Misc. 3d 128A, 784 N.Y.S. 2d 918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]). Herein, applicant established its *prima facie* entitlement to first party no-fault benefits by proof that it submitted a claim setting forth the fact and amount of the loss sustained and that payment of no-fault benefits was overdue.

Medical Necessity

If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary, the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. (See *A.B. Medical Services, PLLC v. Geico Insurance Co.*, 2 Misc. 3d 26 [App Term, 2nd & 11th Jud Dists 2003]; *Kings Medical Supply Inc. v. Country Wide Insurance Company*, 783 N.Y.S. 2d at 448 & 452; *Amaze Medical Supply, Inc. v. Eagle Insurance Company*, 2 Misc. 3d 128 [App Term, 2nd and 11 Jud Dists 2003]).

When an insurer relies upon a peer review report to demonstrate that a particular service was not medically necessary, the peer reviewer's opinion must be supported by sufficient factual evidence or proof and cannot simply be conclusory. As per the holding in *Jacob Nir, M.D. v. Allstate Insurance Co.*, 7 Misc.3d 544 (2005) Further, a denial based on lack of medical necessity must be supported by competent medical evidence setting forth a clear factual basis and medical rationale for denying the claim. *Citywide Social Work, & Psy. Serv. P.L.L.C. v Travelers Indemnity Co.*, 3 Misc. 3d 608 (Civ. Ct. Kings Co. 2004)

Respondent timely denied the claim at issue here based upon the peer review report prepared by Ronald Mann, M.D. dated December 16, 2022. Dr. Mann performed a surgical peer review finding the procedure not to be medically necessary, he provided a history of the EIP's treatment and opines in relevant part:

"The claimant's past medical history was unremarkable. MRI report of the right shoulder dated 9/8/2022, revealed tendinosis of anterior fibers of the supraspinatus. Anteroinferior labral tear... According to the orthopedic

follow-up evaluation report dated 10/13/2022, by Robert Drazic, D.O., the claimant presented with complaints of pain in the right shoulder. Pain scale was 7/10. The claimant is not taking any medication. Physical examination of the right shoulder revealed limited range of motion. Clinical impression was of left shoulder rotator cuff tear; left shoulder labrum tear; left shoulder rotator cuff tendinitis. Plan: the claimant was recommended right shoulder arthroscopy... MRI report of right shoulder revealed " Tendinosis of anterior fibers of the supraspinatus; anteroinferior labral tear. " These findings do not necessitate a rush surgery. Right shoulder surgery was not medically necessary. There was an inadequate attempt at conservative care. Therefore, right shoulder surgery was not medically necessary at that stage of the claimant's injuries. There was no evidence that the claimant completed a full proper course of conservative management prior to considering right shoulder arthroscopy. The doctor should have provided the claimant with proper conservative therapy consisting of physical therapy, and steroid injections before considering alternative treatment options. Therefore, surgery was not an appropriate treatment option for this claimant... Standard of care is physical therapy for at least 3-6 months and analgesics and the doctor deviated from standard by prescribing surgery before conservative therapy could be completed"

Dr. Cohen cites to medical authority in order to support his conclusion.

On June 16, 2023 Dr. Cohen prepared an addendum to his peer review in response to the rebuttal prepared by Pervaiz Qureshi, M.D. dated May 22, 2023. Dr. Mann indicates his opinion remains unchanged noting the Standard of care is physical therapy for at least 3-6 months and analgesics and the doctor deviated from standard by prescribing surgery before conservative therapy could be completed.

Where the Respondent presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden then shifts to the Applicant which must then present its own evidence of medical necessity. [see Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11th ed]], *Andrew Carothers, M.D., P.C. v. GEICO Indemnity Company*, 2008 NY Slip Op 50456U, 18 Misc. 3d 1147A, 2008 N.Y. Misc. LEXIS 1121, *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.* 13 Misc.3d 131, 824 N.Y.S.2d 759, 2006 NY Slip Op 51871(U) (Sup. Ct. App. T. 2d Dep't 2006)].

I find that Respondent's peer review meets the above burden and I will look to Applicant to refute the conclusions reached by the peer reviewer. After reading all the submissions including the medical records, the peer review the Rebuttal by Pervaiz Qureshi, M.D. dated May 22, 2023 and the addendum. I find that Applicant has set forth sufficient evidence to refute the conclusion reached by the peer reviewer.

The Applicant's evidentiary submission consist of the medical reports form the treating/surgeon as well as the operative report, imaging studies and a rebuttal prepared by Pervaiz Qureshi, M.D. dated May 22, 2023

Dr. Qureshi's rebuttal provides a medical history of the EIP up until the time of surgical intervention, noting the relevant examinations and follow ups pre surgical intervention. The Applicant further includes the imaging studies that led to the recommendation for surgery. Dr. Qureshi opines in relevant part:

"MRI study of the right shoulder performed on 9/8/2022, revealed tendinosis of anteriorfibers of the supraspinatus, and anteroinferior labral tear... Despite physical therapy, the EIP had no complete relief in her complaints of right shoulder pain. Therefore, she presented at TRI-BOROUGH NY MEDICAL PRACTICE, P.C., for an orthopaedic consultation on 9/29/2022. At that time, she complained of right shoulder pain with overhead activity that had a high degree of hindrance in daily living at home and with other activities. She reported difficulty dressing and especially when lifting heavy loads. The pain was described as sharp, stabbing with a burning sensation with throbbing. Examination of the right shoulder revealed decreased range of motion, diminished strength, tenderness to the anterolateral aspect of the right shoulder joint as well as the bicipital groove, positive Hawkins' sign. The diagnosis was right shoulder internal derangement. Due to non-response to conservative modalities of treatment; the patient was recommended right shoulder arthroscopy. She was also recommended to continue with the ongoing course of physical therapy... On 10/13/2022, Ms. Bello presented to Dr. Robert Drazic. At that time, she complained of 8/10 pain in the right shoulder. Examination of the right shoulder revealed decreased range of motion, diminished strength, tenderness to the anterolateral aspect of the right shoulder joint as well as the bicipital groove, positive Hawkins' sign. Therefore, the patient was scheduled for right shoulder arthroscopy. After discussing all the risks and benefits of the procedure, the patient agreed to schedule the surgery..."

"It should be noted that the decision of shoulder arthroscopy was not solely based on reviews of the report; it was also based on the positive clinical findings throughout the physical examination of the patient. The patient had a combination of subjective complaints and positive clinical findings, which demonstrated the need for surgical intervention. The patient had 8/10 pain in the right shoulder. There was decreased range of motion, diminished strength, tenderness to the anterolateral aspect of the right shoulder joint as well as the bicipital groove, and positive Hawkins' sign. Also, I would highlight that the patient was a right-hand dominant and had pain in the right shoulder. She started to attend therapy after the accident, however, her pain persisted. She had only gained temporary relief from the pain. The pain in her right shoulder caused difficulty with daily activities and interfered with her overall quality of life. The clinical presentation of the patient indicated the presence of a labral tear and rotator cuff tear. Therefore, the patient was recommended right shoulder arthroscopy...."

"Addressing the argument of cortisone injection, I would note that the injections would not be beneficial or indicated for several reasons. One, they do not actually repair anything(especially tears) within the joint and only sometimes temporarily mask some of the symptoms. Furthermore, injections are not efficacious in providing reliable pain relief nor in improving range of motion..."

Dr. Qureshi supports his conclusion of the medical necessity of the procedure and associated services by citing medical authority. The record further includes the operative report dated October 13, 2022 with intraoperative findings consistent with pre-operative diagnosis. The surgery was predicated upon the clinical presentation and imaging study. Dr. Qureshi's rebuttal addresses the issues raised by the peer review and provides a medical rationale for performing the surgical procedure. I find the evidence presented including the rebuttal meaningfully rebut the contentions made by the peer reviewer. As such I am persuaded by the applicant's evidence and find the performance of the surgery medically necessary as such the associated services are medically necessary.

Fee Schedule:

In the alternative Respondent argues the amount billed by the Applicant is above fee schedule.

Respondent has the burden of coming 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, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). See also, *Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co.*, 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that an Applicant's claims were more than 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, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curiam, 2006).

In support of its contention that the Applicant's bill was in excess of the fee schedule, the Respondent submitted a fee audit affidavit prepared by Beth Seidman, CPC, Dated April 17, 2023 who indicates the proper reimbursement for the services provided is \$3,026.24

The affidavit prepared a thorough review of the codes presented and provides the calculations for the determination made, she concludes that under the NY fee schedule the proper fee would be \$3026.24 noting that Modifier 59 is an often-misused modifier due to having an impact on reimbursement. The modifier 59 should not be appended to the codes just because it is permissible to be used or that it "will turn off consolidation and allow payment". The documentation must be reviewed to ensure the appropriateness of modifier 59. The documentation does not support the use of modifier 59. I find that Ms. Mallory a certified medical coder, is qualified to review the subject bill and make the fee determination that was set forth on Respondent's denial (see *Mount Sinai Hospital, as Assignee of Maria Figuerdov, Respondent v. Triboro Coach, Incorporated*, 263 A.D.2d 11, 699 N.Y.S.2d 77 (2nd Dept. 1999). I am persuaded by Ms. Seidman's interpretation of the fee schedule and find it sufficiently explained the Respondent's fee schedule defense. Applicant has not uploaded any evidence to the contrary.

Accordingly, in light of the foregoing, based on the arguments of counsel and after a thorough review and consideration of all submissions, I find in favor of the Applicant and award Applicant's claim 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
	Global Surgery Center LLC	10/13/22 - 10/13/22	\$10,095.09	Awarded: \$3,026.24
Total			\$10,095.09	Awarded: \$3,026.24

- B. The insurer shall also compute and pay the applicant interest set forth below. 02/17/2023 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 has 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

The insurer shall pay the applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(d) 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 newly promulgated 11 NYCRR 65-4.6(d). This amendment takes into account that the maximum attorney fee has been raised from \$850.00 to \$1,360.00.

- 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 Nassau

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

11/07/2023

(Dated)

Marcelo Vera

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:
739b4cf2ea7a90989305e8b706f3393b

Electronically Signed

Your name: Marcelo Vera
Signed on: 11/07/2023