American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Andrew Hall MD PLLC (Applicant)	AAA Case No.	17-22-1247-7590
	Applicant's File No.	DK22-253433
- and -	Insurer's Claim File No.	7003739283-1
	NAIC No.	21687
Mid-Century Insurance Company (Respondent)		

ARBITRATION AWARD

I, Nicholas Tafuri, 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 (BA)

1. Hearing(s) held on 11/02/2023
   Declared closed by the arbitrator on 11/02/2023

   Jennifer Raheb from Korsunskiy Legal Group P.C. participated virtually for the Applicant

   Daniel Truong from Mid-Century Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$2,309.65**, 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

   EIP (BA), is a 69-year-old female, who was involved in a motor vehicle accident on November 14, 2021. Following the accident, EIP sought medical treatment. Health services are provided by Applicant on February 25, 2022.

   Applicant's claim for reimbursement, for the health services provided, was partially paid, and the balance denied, based on the fee schedule.

The issue to be determined at the hearing: Whether Respondent's fee schedule defense is sustainable?

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the ADR Center Record as of the date of the hearing and this Award is based upon my review of the Record and the arguments made by the representatives of the parties at the Hearing. Pursuant to 11 NYCRR 65-4 (Regulation 68-D), §65-4.5 (o) (1), an 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 case was decided on the submissions of the Parties as contained in the ADR Center Record maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses.

EIP (BA), is a 69-year-old female, who was involved in a motor vehicle accident on November 14, 2021. Following the accident, EIP sought medical treatment. Health services are provided by Applicant on February 25, 2022.

It is well settled that an Applicant establishes its *prima facie* showing of entitlement to No-Fault benefits by submitting evidentiary proof that the prescribed statutory billing forms had been mailed, received by the respondent and that payment of no-fault benefits were overdue. Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D. 3d 742, 774 N.Y.S.2d 564 (2d Dept. 2004). I find Applicant establishes a *prima facie* case of entitlement to No-Fault compensation for its claim. The burden then shifts to Respondent to prove that the bill in question was properly partially reimbursed.

Applicant's claim for reimbursement, for the health services provided, was partially paid, and the balance denied, based on the fee schedule.

FEE SCHEDULE

The insurer has the burden of proving that the fees charged were in excess, and not in accordance, with the Worker's Compensation fee schedule. St. Vincent Medical Care PC v. Countrywide Insurance Company, 26 Misc. 3d 146 (A), 907 NYS 2d 441 (App. Term 2d, 11th and 13th Dists. 2010). If the

insurer fails to demonstrate, by competent evidentiary proof, that the claims were in excess of the appropriate fee schedule, the defense of noncompliance cannot be sustained. See, Continental Medical PC v Travelers Indemnity Company, 11 Misc.3d 145(a), 819 NYS 2d 847 (App Term 1st Dept. 2006).

Applicant submitted two (2) bills for services associated with a discectomy, performed on 2/25/22. In issuing partial payments for both bills, Respondent cited to Surgery Ground Rule 5 and Surgery Ground Rule 12F. In one bill, Applicant sought reimbursement in the amount of $10,947.63. Respondent issued partial payment, in the amount of $8,886.47. In the second bill, Applicant sought reimbursement in the amount of $1,171.40. Respondent issued partial payment, in the amount of $922.22.

Respondent supports its fee schedule defenses based on a report from Noreen McLoughlin, CCS-P, dated 5/27/22. Citing to Surgery Ground Rule 5 and the multiple procedure rule, Respondent's coder calculates Applicant's reimbursement claim for the codes billed as follows: 63075 (highest allowance)-$3,617.86; 63076 (procedure exempt from the multiple procedure rule)-$1,214.35; 22526 59 (50% reduction based on the multiple procedure rule)-$1,369.30; 22527 (procedure exempt from the multiple procedure rule)-$2,217.07; 62291 59 (50% reduction based on the multiple procedure rule)-$206.59; and 72285 26-paid per NY fee schedule-$261.30. Reimbursement amount = $8,886.47. For the services performed by a physician assistant, Respondent's coder calculates Applicant's reimbursement claim based on Surgery Ground Rule 12F (10.7%--modifier 83), as follows: 63075 83 (highest allowance)-$387.11; 63076 83 (procedure exempt from the multiple procedure rule)-$129.94; 22526 83 59 (50% reduction based on the multiple procedure rule)-$146.52; 22527 83 59 (procedure exempt from the multiple procedure rule)-$237.23; 62291 83 59 (50% reduction based on the multiple procedure rule)-$22.11; and 72285 26 is included in the surgical procedures performed, and 72285 26 is a separate reportable service usually by a radiologist. Reimbursement amount = $922.91. Ms. McLaughlin concludes that based on the partial payments previously issued, no additional reimbursement is owed.

Based upon a review of the coder affidavit, I am persuaded by its content and analysis, and I find that Respondent's fee schedule defense is sustainable.

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., 24 Misc.3d 58, 884 N.Y.S.2d 558 (App. Term 2d, 11th & 13th Dists. 2009).

After careful review of the evidence, I find that the fees the Applicant charged for the services in dispute herein exceeded the relevant fees set forth in the fee schedule. Significantly, Applicant fails to submit any documentary evidence to dispute the substance of Respondent's proof. As such, I find that Applicant has failed to refute the insurer's interpretation of the fee schedule. See Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A), 2011 N.Y. Slip Op. 50040 (U) (App. Term 1st Dept. 2011): Cornell Medical, P.C. v. Mercury Casualty Co., 24 Misc.3d 58, 2009 N.Y. Slip Op. 29228 (App. Term 2d, 11th and 13th Jud. Dists. 2009).

Accordingly, based on the foregoing, Applicant's claim, for additional reimbursement, for date of service 2/25/22, is denied.

This decision is in full disposition of all claims for no-fault benefits presently before this arbitrator.

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 claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of NY
SS :
County of Nassau

I, Nicholas Tafuri, 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)

Nicholas Tafuri

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:
34b208c618420997e59c8c23b8d51d04

Electronically Signed

Your name: Nicholas Tafuri
Signed on: 11/07/2023