American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Restoration Sports & Spine Center (Applicant)	AAA Case No.	17-23-1294-7733
	Applicant's File No.	NF3734529
- and -	Insurer's Claim File No.	89736093500000001
	NAIC No.	22055
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Gregory Watford, 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: Assignor (KK)

1. Hearing(s) held on 10/17/2023
   Declared closed by the arbitrator on 10/17/2023

   Andrew Ciccaroni from The Law Office of Thomas Tona, PC participated virtually for the Applicant

   Heather Pliszak from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$1,716.05**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant amended the amount in dispute to $1,628.25.

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

3. Summary of Issues in Dispute

   The dispute arises from the underlying automobile accident of June 22, 2022, in which the Assignor, a 28-year-old male was a driver. As a result of the impact, he complained of injuries to his neck and back. Thereafter, he sought private medical attention where he was recommended to commence course of conservative care treatments including pain management services.

On October 20, 2022, Assignor underwent a pain management procedure in the form of a cervical epidural steroid injection (CESI). In dispute in this case are the fees for the CESI, the related in-office evaluation, the related epidurography, fluoroscopy and the related contrast (Q9966). Applicant timely submitted the bill to Respondent for payment. Respondent partially paid $87.80 for the in-office evaluation and timely denied payment based upon the peer review of Dr. Jeffery Beer, dated 12/6/22. Respondent also denied payment of the balance based upon Applicant billed in excess of the amounts permitted under the fee schedule.

The issues to be decided in this case are:

Whether Applicant established entitlement to No-Fault compensation for the CESI and related services provided to Assignor.

Whether Respondent made out a prima facie case of lack of medical necessity and, if so, whether Applicant rebutted it.

Whether Respondent established that Applicant billed in excess of the Fee schedule.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the submissions and documents contained in the American Arbitration Association's ADR Center Electronic Case File (ECF). These submissions constitute the record in this case. This case was decided on the submissions of the parties as contained in the ECF and the oral arguments of the parties' representatives. There were no witnesses.

Pursuant to Insurance Law § 5106(a) and the Insurance regulations, an insurer must either pay or deny a claim for motor vehicle no-fault benefits, in whole or in part, within 30 days after an applicant's proof of claim is received (*see* Insurance Law § 5106[a]; 11 NYCRR 65-3.8[c]; *see also* 11 NYCRR 65-3.5). Infinity Health Products, Ltd. v. Eveready Ins. Co., 67 A.D.3d 862, 864, 890 N.Y.S.2d 545, 547 (2d Dept. 2009). A claimant's prima facie proof of claim for no-fault benefits must demonstrate that the prescribed claim forms were mailed to and received by the insurer and are overdue. Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 506, 14 N.Y.S.3d 283, 290 (2015). Applicant's proof is also in Respondent's denials, which acknowledged receipt of the bills.

After reviewing the record and evidence presented, I find that Applicant established a prima facie case of entitlement to reimbursement of its claim. Viviane Etienne Med Care, PC v. Countrywide Ins. Co., *Id*. Once an applicant establishes a prima facie case, the burden then shifts to the insurer to prove its defense. See Citywide Social Work & Psych. Serv. P.L.L.C v. Travelers Indemnity Co., 3 Misc. 3d 608, 2004, NY Slip Op 24034 (Civ. Ct., Kings County 2004).

Medical Necessity - Peer Review

A presumption of medical necessity attaches to a timely submitted no fault claim. Elmont Open MRI & Diagnostic Radiology, P.C. v. State Farm Ins. Co., 26 Misc.3d 1211(A), 906 N.Y.S.2d 779 (Table), 2010 N.Y. Slip Op. 50053(U) at 3, 2010 WL 157564 (Dist. Ct. Nassau Co., Fred J. Hirsh, J., Jan. 6, 2010). 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 [N.Y. 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 [N.Y. App. Term, 2nd and 11th Jud Dists 2003]).

The purpose of a peer review is to determine whether the service/test provided was medically necessary. The peer reviewer discusses the standard of care in the medical community and offers his/her opinion as to why the service/test at issue falls outside of that standard of care. The peer reviewer buttresses his/her opinion with authoritative texts, treatises, and articles, generally frompeer-reviewed publications.

The courts have held that a peer review report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. See, Jacob Nir, M.D. v. Allstate Insurance Co., 7 Misc. 3d 544 (N.Y. City Civ. Ct. 2005).

A determination of medical necessity must be based on evidence in existence prior to the rendering of the service. Foster Diagnostic Imaging, PC v General Assur Co., 10 Misc. 3d 428 (Civ. Ct. Kings Cty 2005).

Dr. Beer drafted a peer review on behalf of Respondent regarding medical necessity of the LESI and related services. He listed and reviewed Assignor's medical records including evaluation reports, progress notes and diagnostic test results. He then summarized the accident and outlined the treatment of Assignor.

Dr. Beer ultimately opined that the CESI and related services were not medically necessary. Dr. Beer noted "ESIs are more often successful in patients without significant compression of the nerve root and, therefore, in whom an inflammatory basis for radicular pain is most likely. In such patients, a success rate of 75% renders ESI an attractive temporary alternative to surgery, but in patients with significant compression of the nerve root, the likelihood of benefiting from ESI is low (26%)."

He then opined: "The claimant in this case described cervical pain following an automobile accident. However, the claimant's MRI revealed only lateral herniations without evidence of significant nerve impingement. Given that a clear intra-spine pain

generator amenable to injections was not discovered, the epidural steroid injection procedure under review in this case is not considered medically necessary."

He did not recommend payment for any of the services in dispute.

Applicant's counsel argued that the peer review is insufficient to establish medical necessity. Specifically, counsel argued that the peer review is conclusory at best in that it did not refer to the 10/20/22 in-office evaluation on the same date of service for the CESI. The evaluation report detailed the examination findings which were the basis for ordering the CESI on 10/20/2022. Applicant's counsel also argued that Dr. Beer primarily relied upon the findings in the cervical MRI report as the basis for his opinion.

A review of the records in this case corroborated Applicant's counsel's arguments. Specifically, although Dr. Beer listed numerous documents that he reviewed prior to drafting the peer review, the 10/20/22 related follow-up/ pre-procedure report by Dr. Eugene Liu, was not listed or discussed by Dr. Beer in the body of his peer review. There was no discussion of the findings contained therein and how or if the findings would have changed or not changed Dr. Beer's ultimate conclusion that the CESI and related services were not medically necessary. This made the peer review less credible to this arbitrator.

Even if unopposed, a "sparse and confusing opinion…offered by (an insurer's) medical expert," which "reflect(s) the expert's…lack of knowledge as to the assignor's medical condition at the time of the disputed services, "fail(s) to meet its evidentiary burden of establishing the lack of medical necessity of the (services) giving raise to (a provider's) claim for assigned first party no-fault benefits." Webster Ave Medical Pavilion, P.C. v. Allstate Insurance Company, 42 Misc.3d 148(A), 2014 N.Y. Slip Op. 50393(U) (App. Term, First Dept. 2014).

Having carefully considered the submissions of the parties, the relevant case law and the arguments of respective counsel, I conclude that the preponderance of the credible evidence supports a finding in favor of the Applicant, as Respondent has failed to meet its initial burden of proof on the issue of medical necessity.

In light of the foregoing, I find that the peer reviewer's opinion is not based on a sufficient factual basis specific to this Assignor, results in a flawed medical rationale, does not provide a standard of care for the Assignor's injuries, and does not meet Respondent's burden of proof. There is no need to consider Applicant's rebuttal evidence, or lack thereof, since Applicant's claims arrived at this arbitration carrying a presumption of medical necessity, which has not been rebutted by Respondent. See, Millennium Radiology, P.C. v. New York Central Mutual Fire Ins. Co., 23 Misc.3d 1121(A), 886 N.Y.S.2d 71 (Table), 2009 N.Y. Slip Op. 50877(U), 2009 WL 1261666 (Civ. Ct. Richmond Co., Katherine A. Levine, J., Apr. 30, 2009).

Accordingly, Applicant is entitled to be reimbursed in an amount consistent with the fee schedule.

Fee Schedule

Effective April 1, 2013, 11 NYCRR 65-3.8(g)(1) has been amended so that the application of the New York State Workers Compensation fee schedule is no longer a precludable defense, and no payment is due on those claims in excess of the fee schedule. Respondent may present its defense without regard to a timely NF 10. USAA General Indemnity Co. v. New York Chiropractic & Physical Therapy, PLLC, 60 Misc.3d 254 (Civ. Ct. Richmond Co., Lisa Grey, J., May 1, 2018).

On December 11, 2018, a new Fee Schedule was promulgated with an original effective date of April 1, 2019. However, the 34th Amendment to Regulation 83 delayed the Fee Schedule's effective date to October 1, 2020. The services in dispute are governed by the new Fee Schedule.

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. Continental Medical PC v. Travelers Indemnity Co ., 11 Misc.3d 145A, 819 N.Y.S.2d 847, (N.Y. App. Term, 1st Dep't, 2006).

When the issue in contention involves the appropriateness of a billing adjustment based on the fee schedule, Respondent must first demonstrate that it has timely and credibly established the basis for its denial(s) before the burden of proof shifts to the Applicant to establish that Respondent's adjustment was contrary to No-Fault regulations and/or the applicable fee schedule. Applicant must then establish a prima facie case of entitlement to additional reimbursement by demonstrating credible evidence that the adjusted rate of reimbursement was incorrect. (See, Westchester Medical Center v. Nationwide Mut. Ins. Co., 78 A.D.3d 1168, 911 N.Y.S.2d 907 (2d Dept. 2010). As of April 1, 2013, the effective date of the Fourth Amendment to 11 NYCRR 65-3, Respondent is only required to reimburse Applicant in accordance with the applicable fee schedule.

The "burden remains on the insurer to assert a defense that a provider billed in excess of the fee schedule." East Coast Acupuncture, PC v. Hereford Insurance Company, 51 Misc. 3d 441, 26 N.Y.S. 3d 441, 443 (Civil Ct. Kings County 2016) (holding that the new regulation "does not place any additional requirements on the medical provider, such as a requirement, in the general case, to substantiate the calculation of its fees).

If the fees can be determined from a straightforward reading of the fee schedule, no coder affidavit or fee audit is required. Absent a straight-forward reading confirming the correct rate, 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., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006).

In support of its fee schedule defense, Respondent relied upon a Techsource Fee Audit. A review of the fee audit revealed that payment was recommended as billed for all codes except Q9966 - Contrast used during the procedure. Applicant billed $500.00 under this code. The audit recommended payment in the amount of $17.20. The explanation on the audit indicated "THE RECOMMENDED ALLOWANCE FOR THE SUPPLY WAS BASED ON THE ATTACHED INVOICE."

A further review of the ECF revealed that there is an invoice in Respondent's submission for Omnipaque contrast with a cost of $1,719.97. It appears that the audit is recommending reimbursement at 1% of the invoice. However, it should be noted that the audit failed to set forth the basis for the reduction listed, nor is there any reference to any authority justifying the reduction.

Under these facts, I find that some explanation of the reduction is necessary if Respondent is to deny payment or reduce payment for this code. Without some professional expert opinion substantiating the calcualtion in the audit, the fee audit's basis for reimbursement reduction has no evidentiary value. Consequently, Applicant is entitled to be reimbursed as billed for this code.

Applicant's amended amount in dispute ($1,628.25) is consistent with the balance owed after Respondent's payment of $87.80 for the related in-office evaluation. Accordingly, Applicant is awarded $1,628.25.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot, without merit, and/or waived insofar as not raised at the time of the hearing.

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
	Restoration Sports & Spine Center	**10/20/22 - 10/20/22**	**$1,716.05**	**$1,628.25**	**Awarded: $1,628.25**
Total			**$1,716.05**		**Awarded: $1,628.25**

B. The insurer shall also compute and pay the applicant interest set forth below. 04/12/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant's award shall bear interest at a rate of two percent per month, calculated on a pro rata basis using a 30-day month from the date payment became overdue to the date of the payment of the award pursuant to 11 NYCRR 65-3.9. The end date for the calculation of the period of interest shall be the date of payment of the claim. General Construction Law § 20 ("The day from which any specified period of time is reckoned shall be excluded in making the reckoning.")

Where a claim is timely denied, interest shall begin to accrue as of the date arbitration is requested by the claimant unless arbitration is commenced within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the 30th day after proof of claim was received by the insurer. 11 NYCRR 65-4.5(s)(3), 65-3.9(c); Canarsie Medical Health, P.C. v. National Grange Mut. Ins. Co., 21 Misc.3d 791, 797 (Sup. Ct. New York Co. 2008) ("The regulation provides that where the insurer timely denies, then the applicant is to seek redress within 30 days, after which interest will accrue.")

C. Attorney's Fees

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

Respondent shall pay Applicant a separate attorney's fee, in accordance with 11 NYCRR 65-4.6(d). Since the arbitration request was filed on or 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) subject to a maximum fee of $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 Westchester

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

11/16/2023
(Dated)

Gregory Watford

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:
0e0ff088ca2fb92d680c1ceb4578218a

Electronically Signed

Your name: Gregory Watford
Signed on: 11/16/2023