American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Health Wellness Medical Services PLLC (Applicant)	AAA Case No.	17-23-1290-3616
	Applicant's File No.	none
- and -	Insurer's Claim File No.	9WINY07117-03
	NAIC No.	29742
Integon National Insurance Company (Respondent)		

ARBITRATION AWARD

I, Nicole J. Simmons, 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: IP

1. Hearing(s) held on 10/27/2023
   Declared closed by the arbitrator on 10/27/2023

   Jeffrey Datikashvili, Esq. from The Sigalov Firm PLLC participated virtually for the Applicant

   James Scozzari, Esq. from Law Offices of Eric Fendt participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$2,386.74**, 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

   Whether Respondent's denial of Applicant's claim for pre-operative services, based upon a peer review report, can be sustained.

   Whether Respondent's fee schedule defense is sustainable.

   The IP (JP), a 67-year-old male driver, was involved in a motor vehicle accident on 7/23/22. The IP underwent right shoulder arthroscopic surgery on 10/13/22. The instant claim is for preoperative evaluations and services provided on 9/30/22 ($968.10) and 10/6/22 ($1,418.64). The claims were denied based upon the 1/26/23 peer review report

of William Walsh, M.D.Respondent additionally contends that Applicant billed in excess of the applicable provisions of the Workers' Compensation Fee Schedule.

4. Findings, Conclusions, and Basis Therefor

I have reviewed and considered all pertinent documents contained in the American Arbitration Association's ADR Center. The case was decided based upon the submissions of the parties and the oral arguments of the parties' representatives made at the arbitration hearing. There were no witnesses.

The 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 Arbitrator may question any witness or party and independently raise any issue that the Arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations. 11 NYCRR 65-4.5(o)(1). (Regulation 68-D.)

I find that Applicant has established its prima facie case as Applicant has met the requirements enunciated in Ave T MPC Corp. v Auto One Ins. Co., 32 Misc 3d 128[A], 2011 NY Slip Op 51292[U] [App Term, 2d, 11th & 13th Jud Dists 2011]). The Court held that "A no-fault provider establishes its prima facie entitlement to summary judgment by proof of the submission to the defendant of a claim form, proof of the fact and the amount of the loss sustained, and proof that the defendant either failed to pay or deny the claim within the requisite 30-day period, or issued a timely denial of claim that was conclusory, vague or without merit as a matter of law," (see Insurance Law § 5106 [a]; Westchester Med. Ctr. v Nationwide Mut. Ins. Co., 78 AD AD3d 1168 [2010]; see also New York & Presbyterian Hosp v. Allstate31 AD3d 512 [2006]).

Medical Necessity

When an insurer relies upon a peer review report to demonstrate that a 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), the peer reviewer must establish a factual basis and medical rationale to support a finding that the services were not medically necessary, including setting forth generally accepted standards in the medical community. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden to prove that the services were not medically necessary. CityWide Social Work & Psychological Services, PLLC v. Travelers Indemnity Co., 3 Misc.3d 608, 777 N.Y.S.2d 241 (N.Y.Civ. Ct. Kings Co. 2004).

Respondent's denial of the preoperative testing is based upon the 1/26/23 peer review report by Dr. Walsh. He notes that the IP was initially examined on 7/25/22 for complaints of right knee pain. Findings included tenderness and decreased range of motion. The IP commenced physical therapy. An 8/31/22 right knee MRI report noted joint effusion, partial ACL tear, supra and infrapatellar plica, quadriceps and patellar tendinosis/tendonitis, and medial and lateral meniscal tearing. The IP presented to

Robert Drazic, D.O. on 9/6/22 with complaints of right knee pain. The examination of the right knee revealed decreased range of motion with pain, crepitus, and positive McMurray test. The MRI report of the right knee was reviewed. The impressions were right knee internal derangement, ACL tear, medial meniscus tear, and lateral meniscus tear. The treatment plan included a recommendation for right knee arthroscopy. The IP presented on 10/13/22 with similar complains and examination findings. Right knee arthroscopic surgery was performed that date.

Dr. Walsh maintains that the 10/13/22 right knee surgery was not medically necessary, therefore the subject preoperative services, office visits, and diagnostic tests were also not medically necessary. As far as the surgery, Dr. Walsh noted the IP received less than 3 months of physical therapy with only 7 sessions directed to the right knee prior to the recommendation for surgery. Additionally, the IP did not have cortisone injections to the right knee. This treatment was insufficient to evaluate the benefit of conservative treatment. The standard of care of 3-6 months of conservative therapy and cortisone injections was not met in this instance. Dr. Walsh states that it is possible to treat meniscal tears conservatively using anti-inflammatory medications and exercises to strengthen muscles around the knee to prevent joint instability. Dr. Walsh contends that as the surgery was not necessary, the preoperative services were likewise not necessary.

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 Op51871(U) (Sup. Ct. App. T. 2d Dept 2006)]. I find the peer review report of Dr. Walsh sufficient to shift the burden to the Applicant.

Applicant did not submit a formal rebuttal and relies on the IP's records to rebut the peer review report. The records show that the IP sustained a right knee injury as a result of the accident. The IP underwent physical therapy treatment over the course of approximately 3 months. The IP's right knee MRI revealed both meniscal and ACL tears and due to the severity of his injury, his treating physicians determined that surgery was indicated. I further note that Dr. Walsh addressed the necessity of the right knee surgery, but he essentially conceded that the preoperative services would be indicated had the surgery been found to be necessary.

After a thorough review of the medical records and consideration of the arguments advanced by representatives from both parties, I find that Applicant has met its burden in rebuttal. The IP's medical records documented ongoing positive right knee complaints and findings and the MRI revealed multiple right knee tears which I find the IP's records demonstrate were in need of repair.

Based on the foregoing, I find that the IP's evidence rebutted the peer review and established the medical necessity of the preoperative evaluations and testing in dispute.

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., 2006 NY Slip Op 26240, 12 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that an Applicant's claims were in excess of the appropriate fee schedule, Respondent's defense of noncompliance with the appropriate fee schedule 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 Dept, per curiam, 2006).

An arbitrator is permitted to take judicial notice of the workers' compensation fee schedule. See Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 20 (2d Dept. 2009); LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), 2011 NY Slip Op 51721(U) (App Term 2d, 11th & 13th Jud Dists. 2011); Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A), 2011 NY Slip Op 50040(U) (App Term, 1st Dept. 2011).

Respondent must demonstrate by competent evidentiary proof that Applicant's claims were in excess of the appropriate fee schedules, otherwise Respondent's defense of noncompliance with the appropriate fee schedule cannot be sustained. Continental Medical, P.C. v. Travelers Indemnity Co., 11 Misc. 3d.145A (App. Term 1st Dept. 2006).

Respondent failed to submit an affidavit from a billing and/or medical expert explaining why the amount charged by Applicant was improper or what CPT code(s) would have been more appropriate. See, Jesa Medical Supply, Inc. v. Geico Ins. Co., 25 Misc. 3d 1098, 887 N.Y.S.2d 482 (Civ. Ct. Kings Co. 2009). Respondent "did not proffer sufficient evidence to establish as a matter of law that the amounts charged in said claims were in excess of the amounts permitted by the fee schedule." Rogy Medical P.C. v. Mercury Casualty Co., 23 Misc. 3d 132[A], 885 N.Y.S.2d 713 (App Term 2, 11th, & 13th Jud Dists. 2009).

It is well settled that an insurer's unilateral decision to change the Applicant's CPT codes, deny the claim, and/or pay reduced fees for disputed medical services is ineffectual when unsupported by a peer review report or by other proof setting forth a sufficiently detailed factual basis and medical rationale for the code changes, denials, and fee reductions. Summit Medical Services v. American International, 7 Misc.3d 1024(A), 801 N.Y.S.2d 243, (N.Y.Dist.Ct.), 2005; Amaze Medical Supply v. Eagle Insurance Company, 2 Misc.3d 128(A) (App. Term 2nd and 11th Jud Dist. 2003).

In the absence of an affidavit from a certified professional coder, fee audit, or other detailed analysis providing an explanation for how it applied the fee schedule provisions, the Respondent's evidence is insufficient to sustain its burden on this record.

Accordingly, based on the foregoing, Applicant's claim is awarded in its entirety.

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**
	Health Wellness Medical Services PLLC	**09/30/22 - 09/30/22**	**$968.10**	**Awarded: $968.10**
	Health Wellness Medical Services PLLC	**10/06/22 - 10/06/22**	**$1,418.64**	**Awarded: $1,418.64**
Total			**$2,386.74**	**Awarded: $2,386.74**

B. The insurer shall also compute and pay the applicant interest set forth below. 03/13/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The insurer shall compute interest and pay the Applicant the amount of interest computed from the filing date as indicated above at the rate of 2% per month, simple, not compounded, calculated on a pro rata basis using a thirty-day month, and ending with the date of payment of the award.

C. Attorney's Fees

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

The Respondent shall pay the Applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(d) of 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon 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 Nassau

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

11/27/2023
(Dated)

Nicole J. Simmons

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:
37f62b411ee755b1815b1b07f2da58bf

Electronically Signed

Your name: Nicole J. Simmons
Signed on: 11/27/2023