

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

NYC Medical Treatments PC
(Applicant)

- and -

Progressive Casualty Insurance Company
(Respondent)

AAA Case No. 17-23-1288-5996

Applicant's File No. SSA23-107375

Insurer's Claim File No. 22-7015015

NAIC No. 11851

ARBITRATION AWARD

I, Paul Weidenbaum, 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 12/04/2023
Declared closed by the arbitrator on 12/04/2023

Steven Super from Super Associates P.C. participated virtually for the Applicant

Regina Wilcox from Progressive Casualty Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,927.26**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount claimed in No-Fault benefits was amended during the arbitration hearing from \$1,927.26 to \$280.16 in pre-IME charges in addition to \$1,476.30 in post-IME charges, for a total amended amount of \$1,756.46, and the amendment was permitted by this arbitrator.

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

3. Summary of Issues in Dispute

This arbitration arises out of medical services provided to the injured person, a 52 year old male, who was involved in a motor vehicle accident which occurred on 2/24/22.

Whether the post-IME medical services provided to the claimant were medically necessary in light of the Independent Medical Examination [IME] performed by Dr. Seneviratne on 5/9/22?

Whether the Respondent's reduction/denial of the Applicant's claim for reimbursement of No-Fault benefits for all pre-IME dates of service based on fee schedule can be sustained?

4. Findings, Conclusions, and Basis Therefor

This arbitration arises out of medical services provided to the injured person, a 52 year old male, who was involved in a motor vehicle accident which occurred on 2/24/22. Applicant initially sought reimbursement in the sum of \$1,927.26. However, during the arbitration hearing, Applicant's counsel amended the amount claimed in No-Fault benefits to \$280.16 in pre-IME billing together with an additional \$1,476.30 in post-IME billing, for a total of \$1,756.46.

Respondent timely denied reimbursement of the post-IME charges based upon the Independent Medical Examination [IME] performed by Dr. Seneviratne on 5/9/22. The Respondent timely denied any further reimbursement for pre-IME dates of service based on fee schedule. With respect to all post-IME dates of service, the Respondent maintains that the allowable rate of reimbursement is \$1,155.31.

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). 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, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006).

If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant'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).

Respondent may interpose a defense in a timely denial that the claim exceeds the fees permitted by the Workers' Compensation schedules, but Respondent must, at minimum, establish, by evidentiary proof, that the charges exceeded that permitted by law. *Abraham v. Country-Wide Ins. Co.*, 3 Misc.3d 130A, 787 N.Y.S.2d 678, 2004 NY Slip Op 50388U, 2004 N.Y. Misc. LEXIS 544 (App. Term, 2d Dept. 2004).

A brief from Respondent's counsel is not the substantive equivalent of "competent evidentiary proof." Furthermore, if an insurer contests and reduces a medical provider's

fees for medical services rendered, then such reduction must be based upon a medical doctor's peer review or medical analysis of the services rendered vis-à-vis the fees charged and a medical explanation regarding why the charges are best described by another CPT billing code.

The Respondent herein has not submitted any fee audit or fee analysis prepared by any professional fee coder to support its fee schedule defense. It is well established that the insurer has the burden of coming forward with competent evidentiary proof to support its fee schedule reduction or denial. See, *Robert Physical Therapy, P.C. v. State Farm Mutual Automobile Insurance Company*, 13 Misc. 3d 172, 2006 N.Y. Slip Op 26240 (N.Y. Civ. Ct. Kings Co. 2006).

In the absence of such proof, a defense of non-compliance with the appropriate fee schedule cannot be sustained. *Continental Medical, P.C. v. Travelers Indemnity Company*, 11 Misc. 3d 145(A), 2006 N.Y. Slip Op 50841(U) (App. Term 1st Dept. 2006).

While I am permitted to take judicial notice of the Workers' Compensation Fee Schedule, see *Kingsbrook Jewish Medical Center v. Allstate Insurance Company*, 61 A.D. 3d 13, 20 (2nd Dept. 2009); 32 Misc. 3d Lvon Acupuncture, P.C. v. Geico Ins. Co., 144(A), 2011 N.Y. Slip Op 51721(U) (App. Term 2nd, 11th & 13th Jud. Dists. 2011); *Natural Acupuncture Health, P.C. v. Praetorian Ins. Co.*, 30 Misc. 3d 132(A), 2011 N.Y. Slip Op 50040(U) (App. Term 1 Dept. 2011), a party seeking to have judicial notice taken should furnish the arbitrator or the court with sufficient information to permit the forum to take judicial notice, in the absence of which information it is permissible to decline to take judicial notice of the fee schedule. See *Megacure Acupuncture, P.C. v. Clarendon National Insurance Company*, 33 Misc. 3d 141(A), 2011 N.Y. Slip Op 52199(U) (App. Term 2nd, 11th & 13th Jud. Dists. 2011). See also *Lancer Acupuncture, P.C. v. Amica Insurance Company*, AAA Case No.: 17-14-9049-2478 (Arbitrator Andrew Horn, 4/15/15). The defense of the fees billed not being in accordance with the fee schedule must be rejected where the insurer fails to address how the amount charged by the provider was in excess of the fee schedule. See *Jesa Medical Supply, Inc. v. Geico Ins. Co.*, 25 Misc. 3d 1098, 2009 N.Y. Slip Op 29386 (N.Y. Civ. Ct. 2009). In the matter before me, I find that the Respondent has not submitted sufficient "competent evidentiary proof" in support of its fee schedule reduction/denial. I note that the Respondent has not submitted an affidavit from a professional fee coder explaining or justifying its fee schedule reduction herein. Given the lack of sufficient information and guidance from the Respondent as to the reason for partial payment, I decline to take judicial notice of the fee schedule in the within matter. Accordingly, the Respondent's denial predicated upon a fee schedule defense is vacated, and Applicant is entitled to further reimbursement in the amended sum of \$280.16 for all pre-IME dates of service. In the event that the issue of medical necessity is resolved in favor of the Applicant, reimbursement in the amended sum of \$1,476.30 will be due and owing.

I now turn to a consideration of the Respondent's medical necessity defense predicated upon the IME report of Dr. Seneviratne dated 5/9/22.

Applicant has established its prima facie case with 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]).

The burden shifts to the insurer to prove that the services were not medically necessary. 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 11th 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), 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).

Dr. Seneviratne reports her findings based upon the 5/9/22 IME she conducted as follows:

The claimant has a history of prior motor vehicle accident in March 2021 which resulted in no injuries, in addition to a prior work-related accident, with no mention in the IME report as to whether injuries were sustained as a result of this accident.

The claimant ambulated with a normal gait.

In the cervical spine, there was minimal tenderness to palpation over the cervical paraspinal muscles and the trapezii. There were no muscle spasms. Range of motion was within normal limits. On neurological examination, there were no sensory deficits in the upper extremities. Deep tendon reflexes of the biceps and triceps were present and equal bilaterally. Muscle strength in each range was 5/5. There was no atrophy of the intrinsic muscles of the upper extremities.

In the thoracic spine, there was no tenderness to palpation over the thoracic paraspinal muscles and no muscle spasm. Range of motion was within normal limits.

In the lumbar spine, there was no muscle spasm, although there was minimal tenderness to palpation over the lumbar paraspinal muscles. Range of motion was within normal limits. On neurological examination, deep tendon reflexes were 2+ in the patellar and Achilles tendons. Muscle strength in the lower extremities was graded at 5/5 bilaterally. Sensory examination of the lower extremities, including the medial and lateral thighs, calves and feet were normal. There was no atrophy in the intrinsic muscles of the lower extremities. There was a negative straight leg raising test. the claimant was able to tiptoe and heel walk.

In the shoulders, there was no tenderness to palpation and no crepitus at the joints. Range of motion was within normal limits. There were negative impingement and Neer's signs. There were negative O'Brien's, Yergason's, Speed's, Hawkins, and Drop Arm tests.

In the elbows, there was no tenderness to palpation, and range of motion was within normal limits.

In the wrists and hands, range of motion was within normal limits. There were negative Tinel's and Phalen's signs. There was no atrophy of the thenar muscles. Motion of the digits of the hand was full.

In the hips, there was no tenderness to palpation and range of motion was within normal limits.

In the knees, there was no tenderness to palpation and no evidence of atrophy of the quadriceps. Range of motion was within normal limits. There were negative McMurray's, Lachman's, Anterior Drawer, Posterior Drawer, and Pivot shift tests. There was no patello-femoral crepitus. The knees were stable to varus and valgus stressing.

In the ankles and feet, there was no soft tissue swelling and no tenderness to palpation. Range of motion was within normal limits. There was no sensory loss to light touch or pin prick.

A diagnosis was rendered consisting of cervical and lumbar spine sprain/strain, resolved, in addition to right shoulder sprain/strain, resolved. The claimant's subjective complaints and MRI findings were not correlated by any positive objective clinical findings on the examination performed by Dr. Seneviratne on 5/9/22. There was no evidence of an orthopedic disability.

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 Dep't 2006)].

Applicant submitted the reports of the MRI studies of the claimant's right shoulder [3/18/22], lumbar spine [3/24/22], and cervical spine [3/24/22], which revealed the following findings: moderate tendinopathy/tendonitis of the supraspinatus tendon of the right shoulder and a small joint effusion. The glenohumeral joint was intact. In the cervical spine, there was a 2mm central disc herniation at C4-C5 impressing on the ventral cord; and a 3mm broad-based right paracentral disc herniation impressing on the ventral cord with mild central canal stenosis; and straightening of the cervical lordosis indicative of muscle spasm. In the lumbar spine, there was a 2mm broad-based central disc herniation at L4-L5 and an annular disc bulge impressing on the thecal sac with narrowing of the lateral recesses bilaterally and of the neural foramina bilaterally. Disc herniation and disc bulging contacts the exiting L4 nerve roots bilaterally and the traversing L5 nerve roots bilaterally. There was an L5-S1 annular disc bulge impressing on the thecal sac with narrowing of the neural foramina bilaterally.

Comparing the evidence submitted by each of the parties against the other, I find that I am more persuaded by the Applicant. I find that IME report of Dr. Seneviratne has not set forth an adequate factual basis and medical rationale to support her determination of a lack of medical necessity for the post-IME treatment at issue, and the Applicant has refuted this contention of the IME doctor by a preponderance of the credible evidence. Accordingly, I find in favor of the Applicant, and reimbursement in the amended sum of \$1,476.30 for all post-IME dates of service is due and owing herein.

This decision is in full disposition of all claims for reimbursement of No-Fault benefits presently pending 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 applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Amount Amended	Status
	NYC Medical Treatments PC	03/02/22 - 03/31/22	\$93.94	\$0.00	Denied
	NYC Medical Treatments PC	04/03/22 - 04/28/22	\$76.86	\$76.86	Denied
	NYC Medical Treatments PC	04/04/22 - 04/04/22	\$280.16	\$280.16	Awarded: \$280.16
	NYC Medical Treatments PC	07/18/22 - 07/28/22	\$510.84	\$510.84	Awarded: \$510.84
	NYC Medical Treatments PC	08/12/22 - 08/12/22	\$294.37	\$294.37	Awarded: \$294.37
	NYC Medical Treatments PC	11/29/22 - 11/29/22	\$68.82	\$68.82	Awarded: \$68.82
	NYC Medical Treatments PC	12/12/22 - 12/30/22	\$547.21	\$547.21	Awarded: \$547.21
	NYC Medical Treatments PC	01/20/23 - 01/20/23	\$55.06	\$55.06	Awarded: \$55.06
Total			\$1,927.26		Awarded: \$1,756.46

- B. The insurer shall also compute and pay the applicant interest set forth below. 03/01/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from the filing date for this case, 3/1/23, until payment has been made at two percent per month, simple interest, on a pro rata basis using a thirty day month.

C. Attorney's Fees

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

After calculating the sum total of the first party benefits awarded in this arbitration plus the interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20% of that sum total, subject to a minimum of \$60 and a maximum of \$850. See 11 NYCRR Section 65-4.6(c) and (e). However, if the benefits and interest awarded thereon are less than or equal to Respondent's written offer during the conciliation process, the attorney's fee shall be based upon the provisions of 11 NYCRR Section 65-4.6(b). For cases filed after February 4, 2015 there is no minimum fee and 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, Paul Weidenbaum, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

12/11/2023
(Dated)

Paul Weidenbaum

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:
5ac6e969e9af80320227b22baed0c5a6

Electronically Signed

Your name: Paul Weidenbaum
Signed on: 12/11/2023