American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Uptown Healthcare Management Inc d/b/a East Tremont Medical Center (Applicant)	AAA Case No.	17-23-1327-8846
	Applicant's File No.	23-007431
	Insurer's Claim File No.	8776782920000001
- and -	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Christopher Persad, 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 L.B.

1. Hearing(s) held on 04/24/2024
   Declared closed by the arbitrator on 04/24/2024

   Jared Mallimo, Esq. from The Licatesi Law Group, LLP participated virtually for the Applicant

   Joan Patricia Knight-Mingo, Esq. from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$7,443.59**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bill. They also stipulated that Respondent's Form NF-10 denial of claim form was timely issued. Additionally, they stipulated that should the Applicant prevail, interest would accrue as of the date noted on the initiation letter.

3. Summary of Issues in Dispute

The Applicant appeared via ZOOM by Video.

The Respondent appeared via ZOOM by Video.

Was the applicant entitled to reimbursement for services (*right knee partial medial and lateral meniscectomies, extensive synovectomy, Coblation arthroplasty multiple compartments, debridement of partial ACL tear*) provided to the EIP L.B. (Twenty-Nine-year-old Male) relative to an August 22, 2023, motor vehicle accident (MVA) in which he was a restrained driver?

Applicant seeks payment for the services provided to the EIP on October 22, 2023.

Respondent denied the claim based upon lack of medical necessity based upon peer reviews by Mukund Komanduri, M.D. dated November 27, 2023.

Respondent raised no issues as to Policy Exhaustion at the time of the hearing.

4. Findings, Conclusions, and Basis Therefor

Medical Necessity

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment Kingsborough Jewish Med. Ctr. v. All State Ins. Co. 2009 NY Slip Op. 00351 (2d. Dep't, January 20, 2009), See also Channel Chiropractic PC v. Country Wide Ins. Co. 38 AD 3d. 294 (1st Dep't, 2007). An insurance carrier must at a minimum establish a detailed factual basis and a sufficient medical rationale for asserting lack of medical necessity. See Vladmir Zlatnick, M.D. v. Travelers Indem. Co. 2006 NY Slip Op. (50963U) (App. Term 1 Dep't, 2006). See also Delta Diagnostic Radiology PC v. Progressive Casualty Ins. Co. 21 Misc. 3d. (142A) (App. Term 2d. Dep't 2008). In evaluating the medical necessity of services with proof of each party, particularly the conclusion is contradictory; consideration must be given to the evidentiary burdens. Respondent must prove first that the services were not medically necessary. A peer review report must set forth a factual basis to establish, prima facie the absence of medical necessity.

Conclusions set forth in peer reviews may be insufficient if it fails to provide specifics of the claim, is conclusory or otherwise lacks a basis in the facts of the claim see Amaze Medical Supply v. All State Ins. Co. 3 Misc. 3d. 43 (App. Term, 2d Dep't, 2004). A peer review report must set forth a factual basis to establish, prima facie the absence of medical necessity. See Nir v Allstate Ins. 7 Misc.3d. 544, 547 (Civ. Ct., Kings Co., 2005) which indicates a respondent's peer review defending a denial of first-party benefits on the ground that the billed-for services were not "medically necessary" must at least show that the services were inconsistent with generally accepted medical/professional practice. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden of proving that the services were not "medically necessary." citing Citywide Social work & Psy. Serv. P.L.L.C. v Travelers Indemnity

Co. 3 Misc. 3d. 608, 616 (Civ. Ct., Kings Co. 2004). A peer report must demonstrate that the services rendered were not in agreement with generally accepted medical or professional standards. Generally accepted practice is the range of practice that the profession will follow in the diagnosis and treatment of the patient in light of the standards and values that define it.

Therefore, an opinion offered by a respondent is more likely to establish a lack of medical necessity when it provides some reference to the standards in the applicable medical community for the services and treatment at issue with an explanation as to when such services and treatment would be medically appropriate with objective criteria and an explanation why it was not medically necessary herein.

I am however not so inclined to preclude the medical opinion offered by an insurer that fails to address the accepted medical/ professional practices. I am inclined, however, to view proof that does address it with much greater weight than one that does not. If the proof of the respondent is found to meet its burden, the proof of the applicant must be considered in opposition to it, mindful that it is likely offered by the provider who actually performed examinations, established treatment and diagnostic plans, made diagnoses and performed medical services.

Peer Review

The Respondent denied the medical services supplied to the EIP per peer reviews by Mukund Komanduri, M.D. dated November 27, 2023. After listing the documents, reviewed prior to writing the peer review, and discussing the EIP's exam findings, the Doctor concludes the services were not medically necessary.

The peer review is not factually sufficient to meet the burden of rebutting applicant's presumption of medical necessity. I find Dr. Komanduri failed to establish that his twelve-week standard of care of physical therapy prior to surgery is an absolute requirement, regardless of any other factors. The records reveals that the claimant had eight weeks of conservative care which failed to provide sufficient relief as it is noted on the October 9, 2023, Initial Orthopedic examination findings of pain at 9/10, locking and clicking, reduced range of motion, reduced muscle strength, and positive Patella Grind, and McMurray's test, resulting in surgery being recommended after it was explained to the claimant that many tears do not fall into the reparable or spontaneously healing categories, however the surgical procedure would remove unstable fragments which would reduce pain. Notably, Dr. Kumanduri's report is factually incorrect as it alleges that no re-exam occurred after the October 9, 2023, exam, and before the surgery, yet the records reveals that the claimant received a full knee examination on October 22, 2023, prior to commencing with the surgery, as well as discussing treatment options once again, before deciding to undergo the instant surgery. This failure to recognize that there was a post initial re-evaluation prior to the surgery undermines the credibility of the entire report. Lastly, Dr. Komanduri acknowledged that the claimant suffered from an "*intrasubstance meniscus tear and partial ACL and PCL tear*" which by his own admission necessitated surgery as referenced in the peer:

> *Further, if physical examination finings and MRI findings are suggestive of injuries to the meniscus, ligament, and tendons that require surgery*

like complex meniscus tears, complete ligament tears or full thickness tears that are traumatic in nature should be repaired surgically.

Accordingly, Respondent is unable to sustain this portion of their asserted defenses.

Fee Schedule

A defendant has the burden to come forward with competent evidentiary proof to support its fee schedule defenses. 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). When a defendant 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. 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. Tm, 1st Dep't, per curiam, 2006). A defendant may interpose a defense in a timely denial that the claim exceeds the fees permitted by the Workers' Compensation schedules, but defendant must, at least, 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. Tm, 2nd Dep't 2004).

Respondent, relying on the Fee Audit by Marta Brzuchacz-Donnelly, CPC, alleges that Applicant billed over the permitted Fee Schedule for CPT Code 29999-59. While that code was billed twice, one instance was noted to be closer in relativity per description when billed under G0289-59 (Surgical knee arthroscopy for removal of loose body, foreign body, debridement/shaving of articular cartilage at the time of other surgical knee arthroscopy in a different compartment of the same knee) however the second instance was determined to be closer in relativity to CPT 29877, which should not be billed along with CPT 29880. Therefore, Respondent asserts that the proper billing for the claim is $5,971.14.

The Applicant relies upon a 3M printout to sustain their billing.

After carefully reviewing and analyzing the evidence with both parties during the hearing and taking judicial notice of the fee schedule (See, Kingsbrook Jewish Med. Ctr v. Allstate Ins. Co., 61 AD3d 13 [2d Dept. 2009]), I find that the Respondent has submitted sufficient evidence to raise a substantial question of fact as to its fee schedule defense as to require the Applicant to come forward with additional evidence in support of its billing. They have not done so. I find Respondent's Fee Audit to be more persuasive as it was prepared by a certified professional coder, and contained an analysis prepared after review of the underlying procedure, with specific reference and discussion of those procedures vis-à-vis the appropriate billing.

Accordingly, Applicant claims are granted in the amount of $5,971.14.

Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of the hearing.

This hearing was conducted using documents contained in the ADR Center. Any documents contained in the folder are hereby incorporated into this hearing. I have reviewed all relevant exhibits contained in the ADR Center maintained by the American Arbitration Association.

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**
	Uptown Healthcare Management Inc d/b/a East Tremont Medical Center	**10/22/23 - 10/22/23**	**$7,443.59**	**Awarded: $5,971.14**
Total			**$7,443.59**	**Awarded: $5,971.14**

B. The insurer shall also compute and pay the applicant interest set forth below. 12/19/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

The respondent shall pay interest at a rate of two percent per month, simple 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

As this arbitration was filed after February 4, 2015, it is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to N.Y. Comp. Codes R. & Regs. tit. 11, § 65-4 (2002) (Insurance Regulation 68-D). Accordingly, the Respondent shall pay the Applicant an attorneys' fee according to § 65-4.6(d).

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

04/24/2024
(Dated)

Christopher Persad

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:
91ebd1eda6489fa1ab1ab492307ae414

Electronically Signed

Your name: Christopher Persad
Signed on: 04/24/2024