

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Empire State Ambulatory Surgery Center
(Applicant)

- and -

Allstate Fire & Casualty Insurance Company
(Respondent)

AAA Case No. 17-24-1338-3519

Applicant's File No. SS-265701

Insurer's Claim File No. 0711049437 2JR

NAIC No. 29688

ARBITRATION AWARD

I, Maureen Callahan, 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

1. Hearing(s) held on 07/17/2024
Declared closed by the arbitrator on 07/17/2024

Greg Itingen from Samandarov & Associates, P.C. participated virtually for the Applicant

Dana Nolan from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$5,820.43**, was AMENDED and permitted by the arbitrator at the oral hearing.

The claim was amended downward at the hearing. Applicant seeks \$4840.65.

Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated and agreed that (i) Applicant has met its prima facie burden by submitting evidence that payment of no-fault benefits are overdue, and proof of its claim was mailed to and received by Respondent; (ii) Respondent's denial of the subject claim was timely issued

3. Summary of Issues in Dispute

CASE SUMMARY

The accident occurred on 4/20/23. The eligible injured party (EIP) is a 30-year-old female driver involved in this accident. The accident caused injuries. On 11/16/23 the EIP underwent a left wrist arthroscopy. This claim seeks reimbursement for the facility fee in connection with that procedure. The claim was denied based upon a peer review of Dr. Stuart Springer. Applicant offers a rebuttal from treating surgeon Dr. Capiola. The issue is whether or not the surgery was reasonable and medically necessary, if respondent meets their burden in denying payment of this claim, and if applicant overcomes same. Respondent also argues that there is a fee schedule dispute.

4. Findings, Conclusions, and Basis Therefor

The accident occurred on 4/20/23. I have reviewed all of the relevant exhibits contained in the electronic file center maintained by the American Arbitration Association. The hearing was held via ZOOM. This decision is rendered upon consideration of the oral arguments made by the parties at the hearing and upon a review of the evidence contained in the case folder as of the date of this hearing.

The Arbitrator, in weighing the evidence, has broad powers and discretion in determining what evidence is relevant and material. The Arbitrator is in the best position to evaluate the evidence and decide on the credibility of the submitted documents."

It is well-settled that a health care provider establishes its prima facie entitlement to reimbursement as a matter of law by proof that it submitted a claim, setting forth the fact and the amount of the loss sustained, and that payment of No-Fault benefits was overdue. *Damadian MRI in Canarsie, P.C. a/a/o Tyrone Harley v. General Assurance Co.*, 2006 NY Slip Op 51048U, Supreme Court of NY, App. Term 2d Dept., June 2, 2006; See Insurance Law Section 5106a, *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 & 11 Jud. th Dists.)]. See also 11 NYCRR Section 65-1.1 *Vista Surgical Supplies, Inc. v. Metropolitan Property and Casualty Ins. Co.*, 2005-1328 KC, 2006 NY Slip Op 51047U, June 2, 2006.

No fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested pursuant to section 65-3.5. It is well settled that an insurer must pay or deny a claim within thirty days of receiving proof of claim. Insurance Law § 5106 [a]; 11 NYCRR 65-3.8(a). *Presbyterian Hosp. in City of N.Y. v Maryland Cas. Co.*, 90 NY2d 274 (1997). An insurer may extend the thirty-day period through the verification procedures set forth in 11 NYCRR 65-3.5. Failure to comply with or extend the thirty-day period results in the preclusion of most defenses, including medical necessity. *Presbyterian Hosp. in City of N.Y. v Maryland Cas. Co.*; *Vista Surgical*

Supplies v. State Farm Mut. Ins. Co., 14 Misc. 3d 135(A) (App Term, 2 and 11 Jud. Dists. 2007). The narrow exceptions to the preclusion rule apply and the to lack of coverage and fraud defenses. See *Central Gen. Hosp. v Chubb Group of Ins. Cos.*, 90 NY2d 195(1997); *Matter of Metro Med. Diagnostics v Eagle Ins. Co.*, 293 AD2d 751 (2002).

The records in this case folder indicate the EIP to be a 31-year-old female seatbelted driver involved in a rear end collision on 4/21/23. There was no loss of consciousness. The EIP sustained injuries to the neck, left shoulder, bilateral wrists, mid and low back. This claim seeks reimbursement for the facility fee incurred in connection with a left wrist arthroscopy performed on 11/16/23.

Applicant has submitted the requisite documentation to make a prima facie case of entitlement to payment. It is well settled that an applicant for no fault benefits establishes a prima facie entitlement to payment by proving that it submitted a claim, set forth the fact and the amount of the loss sustained, and that payment of no fault benefits was overdue. (Insurance Law Sec. 5106 (A); *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5Ad 3d 742; 774 NYS 2d 564; 2004 NY App. Div. Lexus 3597 (2nd Dept.) 2004; *Amaze Med. Supply v. Eagle Ins. Co.*, 2 Misc. 3d 128 A (2003) NY Slip Op. 51701 (App. Term 2d and 11th Jud. Dist.). A facially valid claim is presented where it sets forth the name of the patient, date of the accident, date of service, description of service, and charges for those services. (*Vinings Diagnostic P.C. v. Liberty Mutual Ins. Co.*, 186 Misc. 2d 287; 717 NYS 2d 466 (1st Dis. Ct. Nass. Co.)

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The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, *Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co.*, 2009 NY Slip Op 00351 (App Div 2d Dept., Jan. 20, 2009); *Channel Chiropractic, P.C. v. Country-Wide Ins. Co.*, 2007 Slip Op 01973, 38 A.D.3d 294 (1st Dept. 2007); *Bronx Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co.*, 2007 NY Slip Op 27427, 17 Misc.3d 97 (App Term 1st Dept., 2007), such as by a qualified expert performing an independent medical examination, conducting a peer review of the injured person's treatment, or reconstructing the accident. *Id.* An insurance carrier must, at a minimum, establish a detailed factual basis and a sufficient medical rationale for its asserted lack of medical necessity. *Vladimir Zlatnick, M.D., P.C. v. Travelers Indem. Co.*, 2006 NY Slip Op 50963(U) (App Term 1st Dept., 2006); *Delta Diagnostic Radiology, P.C. v. Progressive Casualty Ins. Co.*, 2008 Slip Op 52450(U), 21 Misc.3d 142(A) (App Term2d Dept., 2008).

A peer review report relied upon by an insurer in timely denying a claim is a proper vehicle to assert the defense of lack of medical necessity. *S & M Supply, Inc. v. Allstate*

Ins. Co., 2003 N.Y. Slip Op. 51191(U) (App. Term 2d & 11th Dists. July 9, 2003); Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp., 2003 N.Y. Slip Op. 50842(U) (App. Term 2d & 11th Dists. Apr. 1, 2003). A peer reviewer must establish a factual basis and medical rationale for his asserted lack of medical necessity of the health care provider's services. See Amaze Medical Supply Inc. v. Allstate Ins. Co., 12 Misc.3d 142(A), 2006 N.Y. Slip Op. 51412(U) (App. Term 2d & 11th Dists. July 12, 2006); Prime Psychological Services, P.C. v. Progressive Casualty Ins. Co., 24 Misc.3d 1244(A), 2009 N.Y. Slip Op. 51868(U) at 3 (Civ. Ct. Richmond Co., Katherine A. Levine, J., Aug. 5, 2009); A.M. Medical Services, P.C. v. Deerbrook Ins. Co., 18 Misc.3d 1139(A), 2008 N.Y. Slip Op. 50368(U) (Civ. Ct. Kings Co., Sylvia G. Ash, J., Feb. 25, 2008). The insurer bears the burden of proof of proving lack of medical necessity as a defense; the claimant does not have to prove the existence of medical necessity. Fifth Avenue Pain Control Center v Allstate Ins. Co., 196 Misc.2d 801, 803 (Civ Ct. Queens Co. 2013).

This claim was timely denied based upon a peer review from Dr Stuart Springer dated 1/8/24. He had a host of records to review in conjunction with his peer review. Basically, he opined the 21 sessions of conservative care was not enough prior to the performance of this surgery. No instability was noted. He relied on the opinions of Dr. Anthony Spataro's IME of 9/14/23, who found that all complaints to the left wrist had been resolved. Applicant argues against this peer review, noting that 21 sessions of therapy, at a frequency of twice a week was almost 10 weeks or 2 ½ months of continuous therapy applicant argues that this would be sufficient. Dr Springer opined that 3 to 6 months would be the medical standard, and the EIP had just short of this, having 2 ½ months therapy. . The applicant also argues that Dr. Springer's reliance upon the IME of Dr. Spataro is misplaced, that he should have relied on his own medical evaluation of the records and not Dr. Spataro's. Moreover, applicant argues in support of a rebuttal from treating Dr. . Capiola of 6/6/24. He notes that the EIP had a tear of the triangular fibrocartilage complex (TFCC) and ganglion cyst to the radiused/scapho joint. On evaluation by Dr. Capiola on 10/18/23, the EIP had a worsening of pain, swelling, stiffness, and weakness. All treatment options were discussed, and the EIP often for the surgical intervention. Based upon his review of all the documents, the EIP's history, complaints, findings and review of records, it was his opinion that performance of the procedure was with generally accepted standards of care.

Once respondent meets his burden, "plaintiff must rebut it or succumb." Bedford Park Medical Practice PC v American Transit Ins. Co, 8 Misc.3d 1025(A), 2005 N.Y. Slip Op. 51282(U) (Civ.Ct. Kings Co. Aug. 12, 2005). Once applicant has established a prima facie case, the burden then shifts to respondent to establish a lack of medical necessity with respect to the benefits sought. See, Citywide Social Work & Psychological Services, PLLC v. Allstate Ins. Co., 8 Misc3d 1025A (2005). A denial premised on lack of medical necessity must be supported by competent evidence such as an IME, peer review or other proof which sets forth a factual basis and medical rational for denying the claim. See, Healing Hands Chiropractic, P.C. v. Nationwide Assur. Co., 5 Misc3d 975 (2004).

Applicant's arguments against the opinions of Dr. Springer and in support of the opinions of Dr. Capiola, are strong and most persuasive. I find in favor of the applicant I

find that applicant has shown that the arthroscopic surgery was reasonable and medically necessary. Objective medical records show there was a tear, and the surgeon recommended this procedure as medically necessary. The applicant has met their burden.

Next, I address the fee schedule. The first bill seeks \$3026.24 for arthroscopy to the wrist, billed at 100%. Respondent's professional coding expert, affidavit by Carolyn Malory, recommends this to be paid. An award will be issued to applicant for procedure. The next code 50% of code 29845, \$1472.45, the synovectomy of the wrist. Applicant also seeks for the periblock, code 76942, \$341.96. , Pursuant to the opinions of coder Malory.

An insurer has the burden of showing as a matter of law that said claims reflect the incorrect amount for services provided. *Jamil M. Abraham, M.D., P.C. v. Country Wide Ins. Co.*, 3 Misc. 3d 130[A], 787 N.Y.S.2d 678 (App Term 2d & 11th Jud. Dist. 2007); *New Era Massage Therapy, P.C. v. Progressive Cas. Ins. Co.*, 2009 N.Y. Misc. Lexis 2554, 242 N.Y.L.J. 2 (Sup Ct. Queens Co. June 26, 2009). I have taken judicial notice of the New York State Workers' Compensation fee schedule. *Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co.*, 61 A.D.3d 13, 20 (2nd Dept.,2009)

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 an Applicant's claims were in excess of the appropriate fee schedules, Respondent'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 argues in support of coder Malory's opinion. She opined that when 2 separate and distinct patient encounters are provided by a single provider on the same day, the pride of either's will need to code modifier 25 or 59 in addition to the column two code to indicate the 2nd code as separate and distinct. She opined that the surgical package concept in the CPT includes preoperative, intraoperative, and postoperative surgical services. She opined that all of these that was recommended for reimbursement for this facility fee. "She cites to the National correct coding initiative edits which state that the provider may to a claim line to indicate multiple, distinct patient encounters provided by the same provider on the same date of service to reflect the nature of the service provided." Code submitted is assigned an APG grouping. Reimbursement is based upon the APG grouping and not the CPT code itself. She recommended payment of \$3026.24 for the facility fee.

If an insurer presents sufficient evidence to substantiate its reduction of a bill pursuant to the Workers' Compensation Medical Fee Schedule, the burden shifts to the medical provider to rebut the carrier's fee schedule interpretation. See, *Natural Acupuncture Health, P.C. v. Praetorian Ins. Co.*, 30 Misc 3d 132A (App Term 1st Dept 2011).

Applicant attempts to meet their burden with an affidavit from Arron Perretta, a coder and an attorney at applicant's firm. He opines that the applicant up be reimbursed for the facility fee for each code, as they are separate and distinct procedures. His position as an employee of the firm arguably somewhat diminishes the appearance of impartiality in rendering his opinion with respect to the fee schedule. I do not find that his opinions overcome the opinions and analysis of coder Malory. Hence, this award will be in favor of applicant. I award \$3026.24 to the applicant.

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
	Empire State Ambulatory Surgery Center	11/16/23 - 11/16/23	\$4,498.69	\$4,498.69	Awarded: \$3,026.24
	Empire State Ambulatory Surgery Center	11/16/23 - 11/16/23	\$1,321.74	\$341.96	Denied
Total			\$5,820.43		Awarded: \$3,026.24

- B. The insurer shall also compute and pay the applicant interest set forth below. 02/28/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

INTEREST: Pursuant to Insurance Law § 5106 (a), interest accrues on overdue no-fault insurance claims at a rate of 2% per month. A claim is overdue when it is not paid within 30 days after a proper demand is made for its payment (Insurance Law § 5106 [a]; 11 NYCRR 65.15 [g]). The Superintendent's regulation tolls the accumulation of interest if the claimant "does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations" (11 NYCRR 65-3.9 [c]). The Superintendent has interpreted this provision to mandate that the accrual of interest is tolled, regardless of whether the particular denial at issue was timely. That interpretation was upheld by the Court of Appeals in LMK Psychological Servs, P.C. v. State Farm Mut. Auto. Ins. Co., 2009 NY Slip Op 02481 (April 2, 2009). Where no denial of claim is issued in response to a proper demand for payment, the insurer does not benefit from the tolling provision and interest will accrue from the date 30 days after the proper demand for payment is made. Interest that accrues when a denial of claim is not issued within 30 days after the proper demand for payment is made will be tolled upon the issuance of a denial of claim, although such denial is untimely, and the failure to request arbitration or institute a lawsuit within 30 days after receipt of that denial of claim form.

C. Attorney's Fees

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

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ATTORNEY'S FEES: 11 NYCRR 65-4.6 establishes a minimum attorneys' fee and further provides that: For cases filed on or before February 4, 2015, the "attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the . . . court, subject to a maximum of \$850" (11 NYCRR 65-4.6 [e]). The October 8, 2003, opinion letter of the Superintendent interpreted that regulation and stated that the minimum amount of attorneys' fees awarded to an assignee health care provider pursuant to Insurance Law § 5106 is "based upon the aggregate amount of payment required to be reimbursed based upon the amount awarded for each bill which had been submitted and denied. The minimum attorney fee . . . is not due and owing for each bill submitted as part of the total amount of the disputed claim sought in the court action" (Ops Gen Counsel NY Ins Dept No. 03-10-04 [Oct. 2003]). For purposes of calculating attorneys' fees, the Superintendent has interpreted a claim to be the total medical expenses claimed in a cause of action pertaining to a single insured, and not each separate medical bill submitted by the provider. The Insurance Department's interpretation of its own regulation was upheld by the Court of Appeals in LMK Psychological Servs, P.C. v. State Farm Mut. Auto. Ins. Co., 2009 NY Slip Op 02481 (April 2, 2009). Attorneys' fees are therefore to be calculated based on the aggregate of all bills for each insured; and Page 4/6 D. For cases filed after February 4, 2015, the attorney's fee 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). The attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant per arbitration or court proceeding, subject to a maximum fee of \$1,360. If the nature of the dispute results in an attorney's fee that could be computed in accordance with the limitations prescribed in both subdivision (c) and this subdivision, the higher attorney's fee shall be payable

- 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 NY

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

07/24/2024

(Dated)

Maureen Callahan

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:
a62c2dbd640329d3d1a156a6c039d35e

Electronically Signed

Your name: Maureen Callahan
Signed on: 07/24/2024