

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

CD Orthopedics, P.C. f/k/a Olympic  
Orthopedics P.C.  
(Applicant)

- and -

Geico Insurance Company  
(Respondent)

AAA Case No. 17-24-1339-9935  
Applicant's File No. 150956  
Insurer's Claim File No. 0461083800101078  
NAIC No.

**ARBITRATION AWARD**

I, Bryan Hiller, 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

1. Hearing(s) held on 07/30/2024  
Declared closed by the arbitrator on 07/30/2024

John Faris Esq. from Law Offices of Eitan Dagan participated virtually for the Applicant

Maria Greenman from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$8,038.14**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount claimed in the Arbitration Request, \$8,038.14 was AMENDED at the oral hearing to \$6,054.00 based on Applicant's fee schedule determination and consent of the parties.

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

3. Summary of Issues in Dispute

Whether Applicant is entitled to reimbursement for left shoulder debridement surgery performed on Assignor on January 14, 2024 in connection with injuries sustained in a motor vehicle accident on November 3, 2023 in light of the Respondent's Peer Review

performed by Dr. Woodley Desir stating that the surgical procedure was not medically necessary?

Whether Applicant billed pursuant to the fee schedule?

#### 4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement, along with interest and counsel fees, under the No-Fault Regulations, for the costs associated with the left shoulder debridement surgery performed on January 14, 2024 in connection with injuries sustained by Assignor in a motor vehicle accident on November 3, 2023. The surgical procedure and associated services were denied following a review of the medical records and a Peer Review report by Board Certified Orthopedic Surgeon Dr. Woodley Desir at Respondent's behest on February 22, 2024 after which the surgical procedure and associated were deemed not medically necessary. In the alternative, Respondent indicated that Applicant billed over the fee schedule. The denial was timely. This decision is based upon the written submissions of counsel for the respective parties as well as oral argument at the hearing conducted on July 30, 2024. I have reviewed the documents contained in the Record as of the date of the hearing.

Assignor, a then 52 year old female restrained driver, was involved in a motor vehicle accident on November 3, 2023. Following the accident, Assignor was taken to the local emergency room where she was evaluated, treated and released. Due to continued symptomology, Assignor came under the care of multiple conservative treatment providers. When pain persisted in the knee despite treatment, Assignor was referred to Applicant CD Orthopedics PC for an initial examination with Dr. Christopher Durant on December 26, 2023. Following the evaluation and previously performed left shoulder MRI, Dr. Durant recommended arthroscopic surgery of the left shoulder. The left shoulder arthroscopy was performed by Dr. Diwan of Applicant CD Orthopedics PC on January 14, 2024 and the notes related to that treatment are attached to the Record.

Applicant establishes its prima facie entitlement to no-fault benefits by proving the submission of statutory claim forms, setting forth the fact and the amount of the loss sustained, and that payment of no-fault benefits was overdue (see Insurance Law § 5106 [a]; *Mary Immaculate Hosp. v Allstate Ins. Co.*, 5 AD3d 742 [2d Dept 2004]). The documents merit out that the Applicant has established its prima facie entitlement to benefits based on the valid submission of the bill and that the Respondent preserved its defense by issuing a timely denial.

Upon proof of a prima facie case by the applicant, the burden shifts to the insurer to prove that the services were not medically necessary (see *A.B. Medical Services, PLLC v. Lumbermens Mutual Casualty Company*, 4 Misc.3d 86, 2004 N.Y. Slip Op. 24194 (App. Term 2d and 11th Jud. Dists. 2004)).

The Respondent must establish a detailed factual basis and a sufficient medical rationale for its asserted lack of medical necessity (see *Delta Diagnostic Radiology, P.C. v.*

Progressive Casualty Ins. Co., 21 Misc.3d 142A, 880 N.Y.S.2d 223 (2nd Dept. 2008)). Additionally, it must be proven that said rationale is supported by evidence of the generally accepted medical/professional practices (see Prime Psychological Servs., P.C. v. Progressive Cas. Ins. Co., 24 Misc.3d 1244A, 901 N.Y.S.2d 902 (Civ. Ct. Richmond Cty. 2009)). Once the Respondent makes a sufficient showing to carry its burden of coming forth with evidence of lack of medical necessity, the Applicant must rebut it (see A. Khodadadi Radiology, P.C. v. NY Central Mutual Fire Insurance, 16 Misc.3d 131(A), 841 N.Y.S.2d 824 (2007)). As a general rule, reliance on rebuttal documentation will be weighed in light of the documentary proofs and the arguments presented at the arbitration. Moreover, the case law is clear that a provider must rebut the conclusions and determinations of the IME/Peer doctor with his own facts (see Park Slope Medical and Surgical Supply, Inc. v. Travelers, 37 Misc.3d 19 (2012)).

The claim was submitted to the Respondent and was denied based upon a Peer Review of Dr. Woodley Desir dated February 22, 2024. The peer reviewer did review the available medical records and outlined the history of the accident as well as the treatment of the patient. Following the review of the records, the Peer Review report was completed by Dr. Desir and the claim was denied as not medically necessary. Dr. Desir argued that the presurgical office visit at Applicant's office revealed minimal findings that would easily resolve with proper conservative treatment, including cortisone or steroid injections. Further, Dr. Desir argued that the Assignor did not go through an appropriate course of non-surgical modalities prior to the surgical intervention. Dr. Desir argued that the MRI only revealed a partial tear and there was no evidence of any significant mechanical symptoms or dislocation so good shoulder function could have been achieved with proper physical training. Based on the limited findings on examination, lack of conservative treatment including injections and the MRI findings, Dr. Desir concluded that the left shoulder surgery was not medically necessary.

The Applicant has submitted the treating records from the performing physicians at Applicant CD Orthopedics PC's facility. First Applicant indicated that MRI clearly indicated rotator cuff and labral tears. Applicant argued that these findings taken in conjunction with the examination findings of tenderness in the right supraspinatus and infraspinatus foss and right trapezius and pectoralis, reduced and painful ranges of motion and positive O'Brien's test were indicative of a significant labral tear. Applicant argued that additional conservative treatment was not the answer for the Assignor as he had undergone physical therapy three times a week for two months and his symptoms had not subsided but had only been exacerbated. Further, Applicant argued that injections would not be beneficial as they did not repair anything within the joint and only temporarily masked the symptoms and explained how the surgical intervention could repair the tear that would get worse if left untreated. Applicant's counsel the treating physician was in the best position to determine the necessity of surgery, especially in a situation where the peer reviewers stretched to claim that the injury and treatment was not necessary despite the significant evaluation and MRI findings.

Comparing the relevant evidence presented by both parties against each other and the above referenced medical necessity standard, I find the Applicant is entitled to reimbursement for the surgical procedures provided to the Assignor. I find the rebuttal

to the peer review sufficient to meet the Applicant's burden on the issue of medical necessity. The rebuttal meaningfully refers to and rebuts the conclusions set forth in the peer review report (see High Quality Medical, P.C. v. Mercury Ins. Co., 26 Misc.3d 145(A), 2010 N.Y. Slip.Op. 50447(U)(Sup. Ct. App. Term 2<sup>nd</sup> Dept 2010)). Specifically, in this matter, the medical records addressed the concerns raised by the peer review regarding the MRI findings. The records established the mechanism of injury and cited to authority regarding the likelihood this can lead to labral tear, which was the case based on the MRI. Additionally, he focuses on the findings on the MRI in correlation with his evaluation to show acute injury both in the form of the effusion on the MRI and the positive O'Brien's test and reduced ranges of motion and tenderness on the examination lead to tears of the labrum and rotator cuff. The clinical examination along with the significant findings in the MRI and the failure to have positive response to conservative treatment show the Applicant made a sufficient case to meet its burden. Further, the treating physicians fully explained how the injuries had to acute in nature due to these findings and the fact that the Assignor was asymptomatic prior to the accident. As such, Applicant is entitled to reimbursement.

### **Fee Schedule**

Applicant originally billed for codes 29823, 29825 and two codes 29999. The total amount originally billed was \$8,898.21 and Applicant amended to \$6,054.00, paying the full amount for CPT code 29823, 50% for the other codes due to the multiple procedure rule and denying one code 29999.

Defendant has the burden to come forward with competent evidence proof to support its fee schedule defenses (see Robert Physical Therapy PC v State Farm Mutual Auto Ins. Co., 2006 NY Slip Op. 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 their position, Respondent relied on the Affidavit of CPC Marta Donnelly. Ms. Donnelly explained how the multiple procedure rule was applied in this matter. Further, Ms. Donnelly argued that an unlisted code can only be reported once per claim for the same anatomic location pursuant to the Ground rules.

In response, Applicant submitted the affidavit of CPC Theresa Carbone dated April 12, 2024. Ms. Carbone explained how one CPT code 29999 for the lysis was properly crosswalked to CPT Code 29825. Ms. Carbone indicated the other CPT code 29999 was for an extensive bursectomy that was clearly performed in a different area of the shoulder and thus reimbursable.

After careful review of the evidence, this Arbitrator is persuaded by Applicant's fee determination and finds that it is credible. Accordingly, I award Applicant's claim in the amount of \$6,054.00 in full disposition of this matter.

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
	CD Orthopedic s, P.C. f/k/a Olympic Orthopedic s P.C.	01/14/24 - 01/14/24	\$8,038.14	\$6,054.00	Awarded: \$6,054.00
Total			\$8,038.14		Awarded: \$6,054.00

B. The insurer shall also compute and pay the applicant interest set forth below. 03/13/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 11 NYCRR 65-3.9(c). The Superintendent and the New

York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009).

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 no minimum and a maximum of \$1360.00. However, if the benefits and interest awarded thereon is equal to or less than the Respondent's written offer during the conciliation process, the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6 (b).

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

08/01/2024  
(Dated)

Bryan Hiller

**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:**  
f75f76d367d526746434605f85464ba0

### Electronically Signed

Your name: Bryan Hiller  
Signed on: 08/01/2024