American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

UK Sinha Physician PC (Applicant)	AAA Case No.	17-23-1294-9511
	Applicant's File No.	DK23-327352
- and -	Insurer's Claim File No.	0655828796 2TB
Allstate Fire & Casualty Insurance Company (Respondent)	NAIC No.	29688

ARBITRATION AWARD

I, Alison Berdnik, 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: Claimant

1. Hearing(s) held on 07/18/2024
   Declared closed by the arbitrator on 08/01/2024

   Jennifer Raheb, Esq. from Korsunskiy Legal Group P.C. participated virtually for the Applicant

   Omid Khani, Esq. from Law Offices of John Trop participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$608.75**, 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

   The Claimant, SP, a 26-year-old female, was a passenger in a motor vehicle involved in an accident on December 22, 2021. At issue in this proceeding is $608.75 for the physician assistant's services associated with right knee surgery performed December 8, 2022. Respondent denied the claim on the grounds that the services at issue were medically unnecessary and offers a peer review report by Howard Levy, MD dated January 30, 2023 in support. Respondent also contends that Applicant's charges exceed those permitted under the New York State Workers' Compensation Fee Schedule (the "Fee Schedule").

   The issues presented for determination are:

1) Whether the disputed services were medically necessary; and

2) Whether the disputed charges exceed those permitted under the governing fee schedule.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses present to testify at the hearing. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

As a preliminary matter it should be noted that, during the hearing on July 18, 2024, Respondent's counsel represented that basic personal injury protection benefits under the policy *may* be exhausted and counsel was uncertain if any additional benefits were available to the Claimant to satisfy any award issued in Applicant's favor. As of the date of the hearing, Respondent had not offered any evidence suggesting that benefits under the policy were exhausted. Therefore, Respondent was afforded until July 31, 2024 to submit evidence of policy exhaustion, if, in fact, there were no additional benefits available under the policy. To date, Respondent has failed to submit any evidence demonstrating an exhaustion of no-fault benefits and, consequently, the hearing in this matter is closed and the case will be decided on the merits in accordance with the evidence originally submitted by the parties.

An Applicant establishes its *prima facie* showing of an entitlement to judgment as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed, received by the Respondent and that payment of no-fault benefits is overdue. *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.2d 742, 774 N.Y.S.2d 564 (2nd Dept. 2005). A facially valid claim has been defined as one that sets forth the name of the patient, date of accident, date of service, description of services rendered and the charges for those services. *See, Vinings Spinal Diagnostic P.C. v. Liberty Mutual Insurance Company*, 186 Misc.2d 128(A), 784 N.Y.S.2d 918 (2003).

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The submission of Respondent's Denial of Claim Form ("NF-10") establishes that Respondent received Applicant's claim and that Respondent has not paid the claim. *Lopes v. Liberty Mutual Ins. Co.*, 24 Misc.3d 127(A), 2009 N.Y. Slip Op. 51279(U),

2009 WL 1799812 (App. Term 2nd, 11th & 13th Dists. Jan. 26, 2009). Thus, the submission of Respondent's NF-10 in this proceeding is sufficient to satisfy Applicant's burden in this instance.

As such, the burden now shifts to the Respondent to prove that the services were not medically necessary. *Amaze Medical Supply v. Eagle Insurance*, 2 Misc.3d 128(A) (2003). 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. *A. Khodadadi Radiology, P.C. v. NY Central Mutual Fire Insurance*, 16 Misc.3d 131(A), 841 N.Y.S.2d 824 (2007).

It is well-settled that Respondent bears the burden of production in support of its lack of medical necessity defense, which, if established shifts the burden of persuasion to applicant. *See, Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op. 52116 (App. Term 1st Dept. 2006). 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 & 11th Jud. Dists. 2003].)

The trial courts have held that a peer review report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. *See, Nir v. Allstate Ins. Co.*, 7 Misc.3d 544, 547, 796 N.Y.S.2d 857, 860 (Civ. Ct. Kings Co. 2005); *see also, All Boro Psychological Servs. P.C. v. GEICO*, 2012 N.Y. Slip Op. 50137(U) (Civ. Ct. Kings Co. 2012).

In order to prevail, respondent's peer review must address all of the pertinent objective findings contained in applicant's medical evidence. It must then clearly explain why, notwithstanding those findings, the disputed service was inconsistent with generally accepted medical or professional practices. *Amaze Medical Supply Inc. v. Eagle Insurance Co., supra*, 2 Misc.3d 128(A); *Citywide Social Work, et al, v. Travelers Indemnity Company*, 3 Misc.3d 608, 777 N.Y.S.2d 241 (Civ. Ct. Kings Co. 2004). Where other reports in the insurer's papers contradict the conclusion of its peer review, or that the service was not medically necessary, it has failed to make out a *prima facie* case in support of the defense of lack of medical necessity. *Hillcrest Radiology Associates v. State Farm Mutual Automobile Insurance Company*, 28 Misc.3d 138(A), 200 N.Y. Slip Op. 51467(U) 2010 WL 3258144 (App Term 2nd, 11th, and 13th Dists. 2010).

In support of its defense, Respondent offers a peer review report by Howard Levy, MD dated January 30, 2023. Dr. Levy notes the Claimant's involvement in the underlying accident on December 22, 2021, following which she was evaluated at the emergency room and released. The Claimant began receiving acupuncture and physical therapy beginning January 6, 2022. Dr. Levy notes that the Claimant was evaluated on January 10, 2022 by Magda Fahmy, MD for complaints of right knee pain. Following examination, the Claimant was advised to undergo physical therapy. On January 11, 2022, the Claimant was evaluated by Francisco Narvaez, MD for complaints of right knee pain. Following examination, the diagnosis was of bursitis of the right knee. Dr. Levy notes that the Claimant was reevaluated by Dr. Fahmy on February 3, 2022, March 21, 2022, June 20, 2022, and July 25, 2022 for complaints of right knee pain. On August 31, 2022, the Claimant received an injection to the right knee administered by Mona Elkomos (Botros), MD. Dr. Fahmy reevaluated the Claimant again on October 31, 2022. On November 4, 2022, the Claimant was evaluated by Upendra Sinha, MD for her complaints of right knee pain. Following examination, right knee arthroscopy was recommended. Dr. Levy notes that the Claimant was reevaluated by Dr. Sinha on December 5, 2022, following which right knee arthroscopy was again recommended. Upon completion of his review of the records, Dr. Levy concluded that the right knee surgery performed December 8, 2022 was medically unnecessary.

According to Dr. Levy, the standard of care for the symptomatic knee would begin with a course of conservative treatment (including rest, ice, and medication). Most knee problems are greatly improved with physical methods alone. When exercise programs are unable to increase strength and range of motion in the knee after more than a month, should be surgery considered. Dr. Levy maintains that as per the available medical records, the claimant did not receive conservative care in any form to resolve the right knee pain. As per the records, there was no contraindication for the conservative treatment. The claimant should have received adequate conservative treatment in the form of physical therapy and acupuncture treatment before proceeding to the right knee surgery. It was not clear why the right knee surgery was performed without receiving conservative care.

The report of Dr. Levy is sufficient to support Respondent's denial based upon a lack of medical necessity as it maintains a factual basis and medically cogent rationale to support his opinion that the surgical services at issue was not medically 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. *Andrew Carothers, M.D., P.C. v. GEICO Indemnity Company*, 2008 NY Slip Op. 50456U, 18 Misc.3d 1147A, 2008; *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.*, 13 Misc.3d 131, 824 N.Y.S.2d 759 (App. Term 2nd Dept. 2006).

In support of its claim, Applicant relies upon the medical reports contained in evidence in the record below. Applicant also offers a report by Upendra Sinha, MD, the Claimant's surgeon, prepared specifically in rebuttal to the peer review.

Comparing the relevant evidence presented by both parties against each other, and upon consideration of the oral arguments presented by counsel, I find that the rebuttal by Dr. Sinha meaningfully refers to and rebuts the assertions of Dr. Levy. The rebuttal addresses the points set forth by Dr. Levy and presents a cogent medical rationale in opposition. Dr. Sinha demonstrates why he believes the surgery was necessary based upon the examination of the patient and the symptoms presented. The physical therapy progress note included in evidence document that the Claimant attended physical therapy consistently between January 6, 2022 and December 6, 2022. It does not go unnoticed, however, the physical therapy notes reflect that therapy was rendered to the cervical and lumbar spine only. The notes fail to document therapy for the knee. That being said, the physical therapy evaluation report dated January 6, 2022 identify right knee complaints, namely, pain and swelling, and the multiple evaluation reports from Dr. Salibs Medical Practice beginning January 10, 2022 through October 31, 2022, together with the physical therapy prescriptions dated February 22, 2022, March 22, 2022 and May 9, 2022 recommend physical therapy to the right knee. Dr. Sinha's rebuttal indicates that the Claimant had been receiving physical therapy consistently for the knee for months. The acupuncture progress notes document acupuncture to the right knee. While the MRI report is not included in evidence, Dr. Sinha maintains that an MRI of the right knee performed May 15, 2022 revealed, among other things, a partial tear of the anterior cruciate ligament. The August 31, 2022 evaluation report by Mona Elkomos Botros, MD documents an injection to the right knee. While Dr. Levy notes this in his peer review, he fails to provide any meaningful discussion of the injection when rendering his determination that the surgery was not medically necessary. Dr. Sinha's December 5, 2022 report indicates that the Claimant underwent an injection to the right knee with little relief. Overall, the findings in the medical reports submitted by the Applicant support the analysis set forth by Dr. Sinha in the Rebuttal and establish that the Claimant had unresolved objective findings after several months of conservative care, thus warranting surgical intervention. As such, I find the rebuttal factually sufficient to meet the burden of persuasion.

That being said, Respondent also contends that Applicant's charges exceed those permitted under the New York State Workers' Compensation Fee Schedule (the "Fee Schedule").

The rates charged by Applicant must be in accordance with Insurance Law §5108. The services in dispute were performed subsequent to the effective date of the Fourth Amendment to Regulation 68-C (April 1, 2013). 11 NYCRR 65-3.8(g)(1) now states that proof of fact that the amount of loss sustained pursuant to Insurance Law 5106(a) shall not be deemed supplied by an applicant to an insurer and no payment shall be due for claimed medical services under any circumstances: (i) when the claimed medical services were not provided to an injured party; or (ii) for those claimed medical services that exceed the charges permissible pursuant to Insurance Law 5108(a) and (b) and the regulations promulgated thereunder for services rendered by medical providers.

The language of 11 NYCRR §65-3.8(g)(1) does not place any additional requirement on a medical provider to substantiate the calculation of its fees as part of its *prima facie* case. Rather, the burden of asserting a defense that a provider billed in excess of the fee

schedule remains on the insurer, who need not pay the bill if it determines that the bill contravenes the fee schedule. *East Coast Acupuncture, PC v. Hereford Insurance Company*, 51 Misc.3d 441, 26 N.Y.S.3d 441 (Civil Ct. Kings Co. 2016). To be clear, 11 NYCRR 65-3.8(g)(1) does not require an applicant to prove, as part of its *prima facie* case, that the claimed amount aligns with the fee schedule. In terms of what is required, the most notable case on point is *Viviane Etienne Med. Care, P.C. v. Country-Wide Ins. Co.*, 25 N.Y.3d 498, 14 N.Y.S. 3d 283 (2015), which was decided by the Court of Appeals after the Fourth Amendment to 11 NYCRR 65-3 was adopted. In *Viviane Etienne, supra*, the Court was asked to determine what a provider must show in order to establish its *prima facie* entitlement to no-fault benefits. As stated by the Court, this is done by "submitting evidence that payment of no-fault benefits is overdue, and proof of its claim, using the statutory billing form, was mailed to and received by the defendant insurer."

11 NYCRR 65-3.8(g)(1)(ii) is significant to the extent that it enables insurers to assert a fee schedule defense regardless of whether it is preserved in a timely denial. This means that, like an issue of coverage, a fee schedule defense is not precludable. *Surgicare Surgical Associates v. National Interstate Ins. Co.*, 50 Misc.3d 85, 25 N.Y.S.3d 521 (App. Term, 1st Dept., Oct. 8, 2015), *aff'g* 46 Misc.3d 736, 997 N.Y.S.2d 296 (Civ. Ct., Bronx Co., 2014); *Saddle Brook Surgicenter, LLC v. All State Ins. Co.*, 48 Misc.3d 336, 8 N.Y.S.3d 875 (Civ. Ct. Bronx Co., Paul A. Goetz, J., Apr. 7, 2015); *Tyorkin v. Garrison Property & Casualty Ins. Co.*, 51 Misc.3d 1227(A), 2016 N.Y. Slip Op. 50846(U) (Civ. Ct. Kings Co., Richard J. Montelione, J., May 20, 2016).

In *Saddle Brook Surgicenter, LLC v. All State Ins. Co.*, 48 Misc.3d 336, 8 N.Y.S.3d 875 (Civ. Ct. Bronx Co. 2015), the Court found, "The purpose of the [no-fault] statute and the fee schedules promulgated thereunder is to 'significantly reduce the amount paid by insurers for medical services, and thereby help contain the no-fault premium'" (**48 Misc.3d at 340) (*Goldberg v Corcoran*, 153 A.D.2d 113, 118 [2nd Dept. 1989], *quoting Governor's Program Bill*, 1977 McKinney's Session Laws of NY at 2449, and *citing Governor's Mem in Support of Assembly Bill A7781-A*.)

The burden remains on Respondent, however, to come forward with competent evidentiary proof in support of 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 1065(A), 816 N.Y.S.2d 700, 2006 NY Slip Op 50393(U), 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). An insurer who raises a fee schedule defense, "will prevail if it demonstrates that it was correct in is reading of the fee schedules." *Jesa Medical Supply, Inc. v. Geico Ins. Co.*, 2009 N.Y. Slip Op. 29386, 25 Misc.3d 1098, 887 N.Y.S.2d 482 (Civ. Ct. Kings Co. 2009). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were more than 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 145(A), 819 N.Y.S.2d 847, 2006 NY Slip Op. 50841(U), 2006 N.Y. Misc. LEXIS 1109 (App. Term 1st Dept. *per curiam*, 2006).

An insurer's unilateral decision to either change an Applicant's CPT codes, pay reduced fees for disputed medical services, or deny the claim in its entirety, 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, or reductions. *Amaze Medical Supply v. Eagle Insurance Company*, 2 Misc.3d 128(A) (App. Term 2nd and 11th Jud. Dists. 2003). If respondent needs further documentation or additional information for services billed when there is no specific code in the Workers' Compensation fee schedule the insurer needs to request additional verification in accordance with 11 NYCRR 65-3.5(b). *Bronx Acupuncture Therapy v. Hereford Insurance Company*, 2017 NY Slip Op. 50101(U) (App. Term 2nd Dept. 2017), *aff'd* ___ A.D.3d ___, 2019 N.Y. Slip Op. 06059 (2nd Dept. Aug. 7, 2019).

The Appellate Term, Second Department has held that, "after defendant made a *prima facie* showing that the amounts charged by plaintiffs…were in excess of the fee schedules, the burden shifted to plaintiffs to show that the charges involved a different interpretation of such schedules or an inadvertent miscalculation or error." *Cornell Medical PC v. Mercury Cas. Co*., 2009 NY Slip Op 29228 [24 Misc.3d 58].

This case was one of two held before me on the same day involving the same parties and the same underlying surgery (*see* AAA case no. 17-23-1294-9544.) The related matter involved the services rendered by the primary surgeon. In that case, Respondent offered a fee audit by Carolyn Mallory, a certified professional coder with Signet Claim Solutions, LLC in support of its fee schedule defense. Ms. Mallory addressed each CPT code as defined under the New York Workers' Compensation Fee Schedule, referenced the Guidelines and ground rules contained therein, as well as the CPT Assistant. She provided the relative value for each CPT code billed by Applicant, together with the corresponding conversion factor, performed a comprehensive analysis, and concluded that appropriate rate of reimbursement for the primary surgeon's services was $3,751.38. Therefore, Respondent argues that the appropriate rate of reimbursement for the services rendered by the physician assistant is 10.7% of the primary surgeon's fee, or $401.40.

After reviewing the Fee Schedule, and upon comparing the relevant evidence submitted by the parties, and upon consideration of the oral arguments presented by counsel during the hearing, I find that Respondent has met its burden of coming forward with competent evidentiary proof in support of its fee schedule defense. I am persuaded by the evidence presented in both cases that the appropriate rate of reimbursement for the surgical services at issue in this proceeding is $401.40. To its detriment, Applicant does not offer any documentation sufficient to support its position that it is entitled to the charges as billed. Overall, the weight, credibility and persuasiveness of the evidence favors Respondent and, as such, Applicant is awarded $401.40 in full satisfaction of its claim.

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**
	UK Sinha Physician PC	**12/08/22 - 12/08/22**	**$608.75**	**Awarded: $401.40**
Total			**$608.75**	**Awarded: $401.40**

B. The insurer shall also compute and pay the applicant interest set forth below. 04/13/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   Applicant is awarded $401.40, together with applicable interest computed from the date of the filing of the AR-1 until such time as payment is made.

C. Attorney's Fees

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

As this matter was filed after February 4, 2015, this case 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). Accordingly, the insurer shall pay the applicant an attorney's fee in accordance with 11 NYCRR 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 Suffolk

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

08/02/2024
(Dated)

Alison Berdnik

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
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Electronically Signed

Your name: Alison Berdnik
Signed on: 08/02/2024