American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Brain & Spine Surgeons of New York (Applicant)	AAA Case No.	17-24-1343-2273
	Applicant's File No.	202403055731276
- and -	Insurer's Claim File No.	0551805490101109
	NAIC No.	22063
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Anne Malone, 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 09/03/2024
   Declared closed by the arbitrator on 09/03/2024

   George Lewis, Esq. from Law Offices of George T. Lewis, Jr., PC participated virtually for the Applicant

   Brittany DePrimo, Esq. from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$4,522.31**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount claimed was amended by the applicant to $2,261.15 to conform to the appropiate fee schedule in Region III. The respondent agreed with this amount, but did not agree that it was the only fee schedule issue to be determined at this hearing.

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

3. Summary of Issues in Dispute

   The 50 year old EIP reported involvement in a motor vehicle accident on October 23, 2022; claimed related injury and underwent cervical discectomy and fusion surgery provided by the applicant on July 21, 2023.

The applicant submitted a claim for these medical services, payment of which was timely denied partial payment of which was timely made by the respondent based upon its determination of the correct reimbursable amount pursuant to the New York Workers' Compensation Medical Fee Schedule.

The issue to be determined at the hearing is whether the respondent established its fee schedule defense.

4. Findings, Conclusions, and Basis Therefor

This hearing was held on Zoom and the decision is based upon the documents reviewed in the Modria File as well as the arguments made by counsel and/or representative at the arbitration hearing. Only the arguments presented at the hearing are preserved in this decision; all other arguments not presented at the hearing are considered waived.

To prevail in its fee schedule defense, the respondent must demonstrate by competent evidentiary proof that the applicant's claims are in excess of the appropriate fee schedule. If the respondent fails to do so, its defense of noncompliance with the New York Workers' Compensation Medical Fee Schedule cannot be sustained. See Continental Medical, P.C. v Travelers Indemnity Co., 11 Misc. 3d 145A (App. Term 1st Dept. 2006.)

An insurer fails to raise a triable issue of fact with respect to a defense that the fees charged were not in conformity with the Workers' Compensation fee schedule when it does not specify the actual reimbursement rates which formed the basis for its determination that the claimant billed in excess of the maximum amount permitted. See St. Vincent Medical Services, P.C. v. GEICO Ins. Co., 29 Misc.3d 141(A), 907 N.Y.S.2d 441 (App. Term 2d, Dec. 8, 2010.)

A fee schedule defense does not always require expert proof. There are two fee schedule scenarios. The first involves the basic application of the fee codes and simple arithmetic. The second scenario involves interpretation of the codes and often requires testimony and expertise beyond that of a lay individual. I find that the fee schedule issue presented in this case is analogous to the former scenario and does not require an expert opinion.

To support its fee schedule defense, the respondent submitted a copy of a portion of the CPT Assistant relevant to these charges in pertinent part:

CMS payment policy does not allow separate payment

for CPT codes 63042 (Laminotomy...; lumbar) or 63047

(Laminectomy...; lumbar) with CPT codes 22630 or 22633

(Arthrodesis; lumbar) when performed at the same interspace.

If the 2 procedures are performed at different interspaces, the

2 codes of an edit pair may be reported with modifier 59 or XS.

The attorney for the respondent argued that in this instance the procedures were performed in the same interspace and therefore, they cannot be billed together and that modifier 59 is not appropriate.

The applicant submitted a copy of "CCI Results Summary" which essentially makes the same argument. However, the attorney argued that since the respondent did not support is fee schedule argument with an affirmation from a certified professional fee coder, medical professional or other expert to interpret the findings in the CPT Assistant and CCI Results Summary.

After a review of the submissions, I find that it is necessary to support the fee schedule arguments with an expert fee coder and/or medical professional.

Based on the foregoing, I find that the respondent has failed to establish its fee schedule defense.

Accordingly, the applicant is awarded $2,261.15 in disposition of this claim.

Any further issues submitted in the record are held to be moot and/or waived insofar as they were not raised at the time of this hearing. This decision is in full disposition of all claims for no fault benefits presently 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
	Brain & Spine Surgeons of New York	**07/21/23 - 07/21/23**	**$623.77**	**$311.85**	**Awarded: $311.88**
	Brain & Spine Surgeons of New York	**07/21/23 - 07/21/23**	**$3,898.54**	**$1,949.27**	**Awarded: $1,949.27**
Total			**$4,522.31**		**Awarded: $2,261.15**

B. The insurer shall also compute and pay the applicant interest set forth below. 04/08/2024 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." See 11 NYCRR §64-3.9(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. Where a claim is untimely denied, or not denied or paid, interest shall accrue as of the 30th day following the date the claim is presented by the claimant to the insurer for payment. Where a claim is timely denied, interest shall accrue as of the date an action is commenced or an arbitration requested, unless an action is commenced or an arbitration requested within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received

by the claimant. 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 was timely. LMK Psychological Servs. P.C. v. State Farm Mut. Auto. Ins. Co., 12 NY3d 217 (2009.)

C. Attorney's Fees

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

Applicant is awarded statutory attorney's fees pursuant to the no fault regulations. For cases filed after February 4, 2015 the attorney's fee shall be calculated as follows: 20% of the amount of first-party benefits awarded, plus interest thereon subject to no minimum fee and a maximum of $1,360.00. See 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 CT
SS :
County of Fairfield

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

09/04/2024
(Dated)

Anne Malone

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:
5c59c7a335c3ade4ab9bff7ac56e1b46

Electronically Signed

Your name: Anne Malone
Signed on: 09/04/2024