

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Triborough ASC  
(Applicant)

- and -

Progressive Casualty Insurance Company  
(Respondent)

AAA Case No. 17-24-1334-4385

Applicant's File No. 00128551

Insurer's Claim File No. 23-2864017

NAIC No. 24260

**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 09/03/2024  
Declared closed by the arbitrator on 09/03/2024

Mikhail Guseynov, Esq. from Drachman Katz, LLP participated virtually for the Applicant

Danielle Mazzola from Progressive Casualty Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$8,744.97**, was AMENDED and permitted by the arbitrator at the oral hearing.

The claim amount of \$8,744.97, was AMENDED at the oral hearing to \$7,898.75 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 the fees associated with the facility fee for a lumbar percutaneous discectomy, decompression and annuloplasty surgery

performed on November 14, 2023 in connection with injuries sustained in a motor vehicle accident on July 22, 2023 in light of the Respondent's Independent Medical Examination performed by Dr. Ernest Seldman on October 18, 2023?

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 anesthesia for a lumbar percutaneous discectomy, decompression and annuloplasty surgery performed on November 14, 2023 in connection with injuries sustained by Assignor in a motor vehicle accident on July 22, 2023. The treatment was denied following an Independent Medical Examinations conducted by Dr. Ernest Seldman on October 18, 2023 at Respondent's behest after which all treatment was effectively cut-off on November 2, 2023. This decision is based upon the written submissions of counsel for the respective parties as well as oral arguments at the hearing conducted on September 3, 2024. I have reviewed the documents contained in the Record as of the date of the hearing.

Assignor, a then 29 year old male restrained driver, was involved in an automobile accident on July 22, 2023. Following the accident, Assignor did not see any immediate or emergent hospital care. Due to continued symptomology, Assignor came under the care of multiple conservative treatment providers. When symptoms persisted despite treatment, Assignor was referred to orthopedic surgeon Dr. Daniel Feldman. Following evaluation and review of the previously performed MRI, Dr. Feldman recommended the subject lumbar decompression surgery. The facility fee for the decompression surgery on November 14, 2023 was performed at Applicant Triborough ASC's facility and the notes related to the services are attached to the Record.

A health care provider establishes its prima facie entitlement to payment as a matter of law by proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law § 5106 a; *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 AD 3d 742, 774N.Y.S. 2d 564 [2004]). I find that Applicant established a prima facie case of entitlement to reimbursement of its claim by timely submitted valid bills for the surgery at issue. (see *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004)). Since Respondent's denials were timely, it was within its rights to assert that further treatment was medically unnecessary (see *Liberty Queens Medical, P.C. v. Liberty Mutual Insurance Co.*, 2002 NY Slip Op 40420(U), 2002 WL 31108069 (App. Term 2d & 11th Dists. June 27, 2002)).

Respondent timely denied payment of the bills for this treatment performed on November 14, 2023 based upon an Independent Medical Exam (IME) by orthopedic surgeon Dr. Ernest Seldman on October 18, 2023 with an effective cut-off date of November 2, 2023. At the time of the examination, Assignor's complaints referable to the accident included pain in the neck, mid back, low back and left shoulder. On

examination, Dr. Seldman noted pain in the neck, low back, bilateral shoulders and left knee. Dr. Seldman's neurological evaluation found no motor or sensory deficits, bilateral deep tendon reflex function and normal muscle strength in the upper and lower extremities. Examination of the cervical, thoracic and lumbar spines indicated no spasm or tenderness, normal ranges of motion on all planes. Evaluation of the upper and lower bilateral extremities indicated normal ranges of motion on all planes and negative orthopedic testing in the shoulders, elbows, wrist/hands, hips, knees and ankles/feet. Following the evaluation, Dr. Seldman diagnosed cervical, thoracic and lumbar spine sprain/strain resolved, bilateral shoulder sprain/strain resolved, left knee and right ankle sprain/strain resolved and all other areas examined normal examination and determined that the Assignor had no need for further orthopedic related treatment, including physical therapy and surgery.

An IME report asserting that no further treatment is medically necessary must be supported by a sufficiently detailed factual basis and medical rationale, which includes mention of the applicable generally accepted medical/professional standards (see *Carle Place Chiropractic v. New York Central Mut. Fire Ins Co.*, 19 Misc.3d 1139(A), 866 N.Y.S.2d 90 (Table), 2008 N.Y. Slip Op. 51065(U), 2008 WL 2228633 (Dist. Ct., Nassau Co., May 29, 2008, Andrew M. Engle, J.)).

An IME doctor must establish a factual basis and medical rationale for his asserted lack of medical necessity for future health care services (see *Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance*, 20 Misc.3d 144(A), (App. Term 2d & 11th Dists. Sept. 3, 2008)). Where an IME report provides a factual basis and medical rationale for an opinion that services were not medically necessary, and the claimant fails to present any evidence to refute that showing, the claim should be denied (see *AJS Chiropractic, P.C. v. Mercury Ins. Co.*, 22 Misc.3d 133(A), (App. Term 2d & 11th Dist. Feb. 9, 2002)), as the ultimate burden of proof on the issue of medical necessity lies with the claimant (see Insurance Law § 5102; *Wagner v. Baird*, 208 A.D.2d 1087 (3d Dept. 1994)).

If the insurer presents sufficient evidence establishing a lack of medical necessity, then the burden shifts back to the Applicant to present its own evidence of medical necessity (see *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.*, 13 Misc.3d 131A (2006)). Once the insurer [Respondent] makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity, "[Applicant] must rebut it or succumb" (see *Bedford Park Med. Practice P.C. v. American Transit Tr. Ins. Co.*, 8 Misc.3d 1025 (A), 2005, 2005 NY Slip Op 51282 citing *Bauman v Long Island Railroad*, 110AD2d 739, 741, [2d Dept 1985]). As a general rule, reliance on rebuttal documentation will be weighed in light of the documentary proofs and arguments presented at the arbitration. Moreover, the case law is clear that a provider must rebut the conclusions and determinations of the IME doctor with his own facts (see *Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co.*, 37 Misc.3d 19 (App. Term 2d, 11 & 13 Dists. 2012)).

Applicant did not submit a direct rebuttal addressing the findings in the IME but instead argued that the subject surgery was sufficient to rebut the presumptions of the IME. Specifically, Respondent submitted treatment notes which led up to the surgery performed on November 14, 2023, less than two weeks after the effective cut-off date of

the IME. This escalation of treatment included that the Assignor's conditions had not resolved contemporaneously to the IME. Further, the post-surgical follow up indicated that the Assignor had significant relief following the surgical procedure

On the basis of the review of the medical evidence submitted by the parties and listening to the arguments of counsel, I find that Respondent has not met its burden of proving that there was no medical necessity for anesthesia for the lumbar decompression surgery performed on November 14, 2023. Independent Medical Examiner Dr. Seldman failed to appreciate the extent of the injuries in minimizing the findings to indicate sprain/strain when there was clearly established disc pathology in the back. Further, the contemporaneous medical records indicated significant pain, positive findings and noted that the Assignor was receiving a significant course of treatment leading to pain management treatment and eventually surgery. Thus, comparing the relevant evidence presented by both parties and the above referenced medical necessity standard, I find in favor of the Applicant, and award reimbursement for the November 14, 2023 facility fee for the surgical procedure in favor of Applicant.

### **Fee Schedule**

Respondent submitted a fee schedule audit by CPC Sarah Lindenauer. Ms. Lindenauer determined that the appropriate fee was \$5,292.93 based CPT Code 62287 being denied because Modifier 59 was inappropriate used when they were performed in the same operative session as CPT code 62287, the main code for the lumbar discectomy.

Applicant submitted an IHC report which indicated that the add on code of 22899 (same EAPG section at 22526 discussed in the report) can be billed with Modifier 59 according to the NCCI Edits as they are two mutually exclusive separate procedures.

Respondent has the burden of coming forward with "competent evidentiary proof" supporting its fee schedule defenses (see *Continental Med., P.C. v. Travelers Indem. Co.*, 11 Misc.3d 145a (2006)).

An insurer fails to establish the existence of an issue of fact with respect to a defense that fees charged were excessive and not in accordance with the Workers' Compensation fee schedule in the absence of proof establishing the defense (see *St. Vincent Medical Care, P.C. v. Country Wide Ins. Co.*, 26 Misc.3d 146(A), 907 N.Y.S.2d 441 (Table), 2010 N.Y. Slip Op.50488(U), 2010 WL 1063914 (App. Term 2d, 11th & 13th Dists. Mar. 19, 2010)).

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 *Vincent Medical Services, P.C. v. GEICO Ins. Co.*, 29 Misc.3d 141(A), 907 N.Y.S.2d 441 (Table), 2010 N.Y. Slip Op. 52153(U), 2010 WL 5116892 (App. Term 2d, 11th & 13th Dists. Dec. 8, 2010)).

I find that Ms. Lindenauer and the IHC are certified medical coders who has been certified for more than 5 years and are qualified to review the subject bill and make the fee determination that was set forth on Respondent's denial (see Mount Sinai Hospital, as Assignee of Maria Figuerdov, Respondent v. Triboro Coach, Incorporated, 263 A.D.2d 11, 699 N.Y.S.2d 77 (2nd Dept. 1999). After reviewing the affidavits, I find that I am more persuaded by the IHC report (see Cornell Medical P.C. v. Mercury Casualty Co., 24 Misc. 3d 58, 884 N.Y.S.2d 558 (App. Term 2d. 11th & 13th Dists. 2009).

The medical documentation provided by the Applicant supports the fee schedule determinations and calculations of the IHC report. Accordingly, I find that Respondent has failed to establish its fee schedule defenses and Applicant's claims is granted in the full claim amount of \$7,898.75 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
	<b>Triborough ASC</b>	<b>11/14/23 - 11/14/23</b>	<b>\$8,744.97</b>	<b>\$7,898.75</b>	<b>Awarded: \$7,898.75</b>
<b>Total</b>			<b>\$8,744.97</b>		<b>Awarded: \$7,898.75</b>

- B. The insurer shall also compute and pay the applicant interest set forth below. 01/30/2024 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.

09/05/2024  
(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:**  
aa9b8ce265d5b351b6088115ff3b0db4

### Electronically Signed

Your name: Bryan Hiller  
Signed on: 09/05/2024