American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Safe Anesthesia & Pain LLC (Applicant)	AAA Case No.	17-23-1295-1417
	Applicant's File No.	177.886
- and -	Insurer's Claim File No.	8757178060000001
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Hersh Jakubowitz, 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 08/28/2024
   Declared closed by the arbitrator on 08/28/2024

   Sakrit Srivastava from Tsirelman Law Firm PLLC participated virtually for the Applicant

   Rachel Hochhauser from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$13,050.00**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Claim amount amended to $726.53.

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

   The Parties stipulated that Applicant had met its prima facie burden of proof and that Respondent's denials were interposed in a timely fashion.

3. Summary of Issues in Dispute

Applicant seeks reimbursement, along with interest and counsel fees, under the No-Fault Regulations, for the costs associated with the Applicant providing anesthesia for right shoulder arthroscopy on October 10, 2022, in connection with injuries allegedly sustained by EIP in a motor vehicle accident on July 7, 2022. The payment, for providing anesthesia, was denied, following a Peer Review by Dr. Howard Kiernan, M.D., at Respondent's behest, as not medically necessary. The denial was timely. This decision is based upon the written submissions of counsel for the respective parties contained within the electronic case file maintained by the American Arbitration Association as well as oral argument at the hearing conducted on August 28, 2024.

4. Findings, Conclusions, and Basis Therefor

History

The dispute arises from a motor vehicle accident on July 7, 2022, in which the EIP, a then 60-year-old male was the restrained driver and sustained numerous injuries. EIP commenced on a course of physical therapy. He was also referred for an MRI study of right shoulder. MRI study of right shoulder revealed rotator cuff tendinopathy and bursitis.

EIP consulted Dr. John Mitamura, M.D. complaining of severe right shoulder pain. Examination of the EIP's right shoulder revealed wasting of the supraspinatus fossa, tenderness upon palpation, diminished range of motion, positive Crossover test, positive Neer Impingement sign with significant pain and positive Lift-off test. The diagnosis was: right shoulder tendinopathy with glenoid labral tearing. Therefore, the EIP was recommended right shoulder arthroscopy. On October 10, 2022, EIP underwent manipulation under anesthesia with lysis and resection of adhesions, rightshoulder, Glenoid labral resection, Rotator cuff debridement, Chondral smoothing, chondroplasty, Lateral clavicular resection including the articular portion, Mumford procedure, Extensive joint debridement, Extensive bursectomy and synovectomy. Applicant provided the anesthesia for the surgery and seeks reimbursement.

Prima Facie

The Applicant has established its prima facie case by proof that the prescribed statutory billing forms had been received and that payment of no-fault benefits was not forthcoming. (See, New York & Presbyt. Hosp. v. Countrywide Ins. Co., 44 A.D.3d 729 [N.Y. App. Div. 2d Dep't 2007]). Proof of the receipt of the Applicant's billing is implicit in the timely denial issued by the Respondent. The Respondent's obligation is to now demonstrate the validity of its denial.

Denial

The Respondent's denial raised the asserted absence of medical necessity based on the analysis of its designated peer, Dr. Howard Kiernan, M.D., The corresponding report dated; October 31, 2022 has been submitted in support of the Respondent's position.

In considering the issue being presented, I note that as part of its prima facie showing, the Applicant is not required to show that the contents of the statutory no-fault forms themselves are accurate or that the medical services documented, therein, were actually rendered or necessary. Stated another way, the Applicant is not required to establish the merits of the claim to meet its prima facie burden. (Viviane Etienne Med. Care, P.C. v. Country-Wide Ins. Co., 114 A.D.3d 33, 46, aff'd 25 NY3d 498)

On the contrary, "[m]edical necessity is presumed upon the timely submission of a no-fault claim (see All County Open MRI & Diag. Radiology P.C. v. Travelers Ins. Co., 11 Misc. 3d 131[A], 815 N.Y.S.2d 493, 2006 NY Slip Op 50318[U] [App Term, 9th & 10th Jud Dists 2006]). Thus, ordinarily, it falls to the defense to establish that the billed-for services were not medically necessary." (Park Slope Med. & Surgical Supply, Inc. v. Progressive Ins. Co., 34 Misc. 3d 154[A] [N.Y. App. Term 2012] [concurring opinion, Golia, J.]; see, also, Kings Med. Supply Inc. v. Country-Wide Ins. Co., 5 Misc. 3d 767, 771 [N.Y. Civ. Ct. 2004 ["It is by now firmly established that the burden is on the insurer to prove that the medical services or supplies in question were medically unnecessary {citation omitted}."])

The Respondent, to establish the validity of its denial, on a prima facie level and put the Applicant to its proof, must, as a minimum, demonstrate, both, a factual predicate and medical rationale for the asserted absence of medical justification for the specific service provided to the EIP, and must premise

its contention upon uncontroverted evidence of generally accepted medical standards of care. (See, Nir v. Allstate Ins. Co., 7 Misc. 3d 544, 547 [N.Y. Civ. Ct. 2005])

Thus, the focus falls squarely on the Kiernan report.

Dr. Kiernan contends that the subject surgery and supporting anesthesia were not medically necessary because "*The standard of care for a shoulder injury after a motor vehicle accident would be a trial of conservative treatment with various modalities of physical therapy, and acupuncture applied for at least 3 months. In addition, if the claimant demonstrated persistent pain, which would be characterized as non-responsive to different types of therapy, including painkillers and intensive physical therapy, an operative procedure might be considered after 3 months… As per the available medical records, the claimant did not receive conservative treatment in any form for the right shoulder. Also, there was no evidence that the claimant received a steroid injection for the right shoulder. The claimant should have received adequate conservative treatment in the form of physical therapy, acupuncture treatment, and a steroid injection before proceeding to the surgery. Further, as per the cited article, the doctor may offer surgery as an option for a torn rotator cuff if your pain does not improve with nonsurgical methods. In addition, there was no evidence indicating a full-thickness tear of the right shoulder. It was not clear why the right shoulder surgery was performed without waiting for conservative care to resolve the right shoulder pain… Therefore, the anesthesia infused during the procedure was also not medically necessary.*"

Analysis

Where, as here, a peer review provides a factual basis and medical rationale for the opinions stated, the burden shifts to the provider to refute the carrier's showing with sufficient contrary proof which, if, it is to prevail, tends to establish the medical necessity for the service provided. (See, Pan Chiropractic, P.C. v. Mercury Ins. Co., 24 Misc. 3d 136[A] [N.Y. App. Term 2009]; A.M. Med. Servs., P.C. v. Deerbrook Ins. Co., 18 Misc. 3d 1139[A] [N.Y. Civ. Ct. 2008])

Moreover, the opposing showing must meaningfully refer to, or rebut, the conclusions articulated by the peer (see, Pan Chiropractic, P.C. v. Mercury Ins. Co., supra), and, in the absence of persuasive medical evidence which tends to rebut the insurer's prima facie showing of a lack of medical

necessity, the carrier's position must be sustained. (See, Hong Tao Acupuncture, P.C. v. Praetorian Ins. Co., 35 Misc. 3d 131[A] [App Term 2nd Dept. April 10, 2012])

Rebuttal

In response to the peer review, the Applicant submit a rebuttal by Dr. Pervaiz Qureshi, M.D., which details "*First of all, there is no clear consensus regarding whether physical therapy should be performed for any particular time period prior to proceeding with arthroscopic intervention. However, the EIP in this case indeed underwent appropriate physical therapy sessions to his right shoulder prior to undergoing the right shoulder arthroscopy. EIP suffered from right shoulder post-vehicular injuries in the subject accident on 7/7/2022 and was suspected of having torn glenoid labrum and rotator cuff tear which failed to resolve with nonoperative treatment alone. Any amount of conservative treatment and injections would not heal the tear and would never bring the EIP to the pre-accident state. The goal of conservative treatment is to reduce symptoms, not to heal the tear. Arthroscopic surgery was mainly used to inspect, diagnose, and was also used as the most predictable way of treatment as well as to relieve painful symptoms. Right shoulder arthroscopy would provide the greatest chance of definitive treatment to the EIP. It was medically necessary to perform the suggested arthroscopy to properly diagnose EIP's condition and to objectively verify presence and severity of internal derangement and other right shoulder pathology in quantitative and qualitative terms and achieve better prognosis. This surgery was crucial to provide most specific and maximally effective treatment to this EIP."*

Analysis

Upon consideration of the arguments of counsel and after a thorough review of all submissions I find that Applicant has submitted sufficient evidence to meet its burden of demonstrating that the subject surgery and supporting anesthesia in issue were medically necessary. Respondent sets forth a factual basis and a medical rationale for denying the claim, but the Applicant's rebuttal and medical records indicate a different conclusion, stressing the emergency of the situation and waiting 3 months of therapy would have been injurious to EIP. After carefully weighing the evidence submitted by the parties, I find that Applicant has submitted sufficient

evidence to satisfy its burden of refuting the findings of the peer review and demonstrating the medical necessity of the disputed surgery and anesthesia.

Accordingly, Applicant's claim is awarded.

Fee Schedule

Insurance Law § 5102(a)(1) defines "basic economic loss" as including "all necessary expenses incurred for…professional health services" subject to the limitations of Insurance Law § 5108. Insurance Law § 5108 limits the amounts to be charged by providers of health services, and states that charges for services specified in Insurance Law § 5102(a)(1) "shall not exceed the charges permissible under the schedules prepared and established by the chairman for the workers' compensation board…except where the insurer…determines that unusual procedures or unique circumstances justify the excess charge." 11 NYCRR § 65-3.16(a) provides that "[p]ayment for medical expenses shall be in accordance with fee schedules promulgated under section 5108 of the Insurance Law and contained in Part 68 of this Title (Regulation 83)." 11 NYCRR § 68.1 provides that the "existing fee schedules prepared and established by the chairman of the Workers' Compensation Board…are hereby adopted by the Superintendent of Insurance with appropriate modifications so as to adapt such schedules for use pursuant to section 5108 of the Insurance Law."

11 NYCRR 65-4.5 (o) (1) (Regulation 68-D), reads as follows: The arbitrator shall be the judge of the relevance and materiality of the evidence offered and strict conformity to legal rules of evidence shall not be necessary. The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems to making an award that is consistent with the Insurance Law and Department Regulations

The Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240 (Civil Ct. Kings Co. 2006). If the Respondent fails to demonstrate by competent evidentiary proof that an

Applicant's claims were billed in excess of the appropriate fee schedules, the defense of noncompliance with the fee schedule cannot be sustained. See,Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A (App. Term 1st Dept. per curiam, 2006).

Respondent's Fee Coder

Respondent submitted a fee analysis by Marta Donnelly, CPC, wherein she indicated that she reviewed the documents submitted by Applicant regarding the anesthesia services rendered to EIP. She opines that. "*The RUV factor was used to calculate compensation level for the service by geographical area and level of service. RVUs, or relative value units, do not define physician compensation in dollar amounts. Rather, RVUs define the value of a service or procedure relative to all services and procedures. This measure of value is based on the extent of physician work, clinical and nonclinical resources, and expertise required to deliver the healthcare service to patients. RVUs determine physician compensation when the conversion factor (CF), dollars per RVU, is applied to the total RVU.*

(1) Total RVUs

(2) Geographic Practice Cost Indices (GPCIs) Region IV

3) Conversion Factor (CF) (Relative Value) X (Anesthesia) =Fee The New York Workers' Compensation Medical fee Schedules now specifically address how providers who render treatment to New York residents out-of-state should be reimbursed. This means that a qualified out-of-state medical provider should be reimbursed (paid) at the rate applicable in the region where the claimant resides (in New York).

CPT 01630-AA -5.00 RUV`s - Start time 8:15AM- Stop time 9:35AM =80 Minutes :15= 6 Units + 5 RUV`s =11 X 29.71=$326.81

CPT 64413-0.73 RUV`s X251.94-$183.92

CPT 64415-0.68 RUV`s X251.94-$171.32 (multiple procedure discount)-$85.66

CPT 76942-59 (unrelated)do not apply 4.97 RUV`s X 58.19-$289.20 -26 modifier -PC/45%-$130.14

Codes for ultrasound or fluoroscopic guidance is utilized for pain management procedures are reported separately with modifier 26 Professional Component unless the code includes imaging guidance (CT or fluoroscopy) -$130.14

Total $726.53 per NYS Fee schedule .

Analysis

The Appellate Term, Second Department stated, "*after defendant made a prima facie showing that the amounts charged by plaintiffs for claims underlying the first and seventh causes of action 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]. The Applicant has not come forward with a different interpretation or calculation. Therefore, the Applicant is awarded $726.53.

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
	Safe Anesthesia and Pain, LLC	**10/10/22 - 10/10/22**	**$13,050.00**	**$726.53**	**Awarded: $726.53**
Total			**$13,050.00**		**Awarded: $726.53**

B. The insurer shall also compute and pay the applicant interest set forth below. 04/14/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Based on the submission of a timely denial, interest shall be paid from the above date, until the date that payment is made at a rate of 2% per month**.**

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 fee, in accordance with newly promulgated 11 NYCRR 65-4(d). After calculating the sum total of the first party benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20% of the sum total, subject to no minimum and a maximum of $1,360.00.

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

09/08/2024
(Dated)

Hersh Jakubowitz

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:
8091d940b797b3cce28b2aa95f7bfbb2

Electronically Signed

Your name: Hersh Jakubowitz
Signed on: 09/08/2024