American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Safe Anesthesia & Pain LLC (Applicant)	AAA Case No.	17-23-1328-9675
	Applicant's File No.	808.253
- and -	Insurer's Claim File No.	0426111050101015
	NAIC No.	35882
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

   Allen Tsirelman, Esq. from Tsirelman Law Firm PLLC 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, **$12,150.00**, 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 39 year old EIP reported involvement in a motor vehicle accident on May 26, 2023; claimed related injury and underwent left shoulder arthroscopic surgery provided at the applicant's facility on August 21, 2023.

   The applicant submitted a claim for these facility services, payment of which was timely denied by the respondent based upon a peer review by Robert Cristoforo, M.D. dated September 13, 2023.

   The respondent also asserted a fee schedule issue.

The issues to be determined at the hearing are:

Whether the respondent established that the left shoulder arthroscopy and related services, including the anesthesia at issue were not medically necessary.

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 from 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.

Medical Necessity

In order to support a lack of medical necessity defense respondent must "set forth a factual basis and medical rationale for the peer reviewer's [or examining physician's] determination that there was a lack of medical necessity for the services rendered." Provvedere, Inc. v. Republic Western Ins. Co., 2014 NY Slip Op 50219(U) (App. Term2d, 11th and 13th Jud. Dists. 2014.) 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.)

The Civil Courts have held that a defendant's peer review or report of medical examination must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review or medical examination 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 specifics as to the claim at issue, is conclusory or vague. See Nir v. Allstate, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005.)

In support of its contention that the left shoulder arthroscopy and related anesthesia services provided by the applicant were not medically necessary, respondent relies upon the report of the peer review by Dr. Cristoforo, who reviewed the medical records of the EIP, noted the injuries claimed and the

treatment rendered to her. Dr. Cristoforo considered possible arguments and justification for the need for the medical services at issue and determined that they were not warranted under the circumstances presented.

He specifically noted that the EIP received less than three months of physical therapy sessions prior to the recommendation for left shoulder arthroscopic surgery.

He concluded that there was no evidence that the EIP completed a full proper course of conservative treatment before considering left shoulder arthroscopy and that her treating physician should have considered an adequate attempt at non-operative treatment first and then, if there was no improvement the surgery should have been considered.

It was Dr. Cristoforo's opinion, supported with relevant medical literature, that the surgery was recommended prematurely and that a complete course of physical therapy could have resolved her symptoms.

Respondent has met its evidentiary burden. The peer review adequately sets forth the factual basis and medical rationale to support the conclusion that the medical services at issue were not indicated for this EIP at the time they were provided. Therefore, pursuant to Bronx Expert Radiology, *supra* the burden shifts to the applicant, which bears the ultimate burden of persuasion to establish that the medical services at issue were medically necessary.

In opposition to the peer review, the applicant did not submit a rebuttal, but relied upon the medical records, including evaluation reports by Dr. Mitamura from May 31, 2023 to August 17, 2023, MRI report of the left shoulder on June 19, 2023 and the operative report.

The left shoulder arthroscopy was performed on August 21, 2021 based on the EIP's history, complaints and clinical findings in accordance with generally accepted standards of care.

After a review of all the evidence submitted, an issue of fact remains as to whether the services rendered are medically necessary. Conflicting opinions have been presented in the peer review by Dr. Cristoforo and the medical records submitted by the applicant.

The medical reports submitted are sufficient to establish the medical necessity for the services at issue.

Based on the foregoing, I find that the respondent has failed to establish that the medical services at issue were not medically necessary.

Therefore, an award may be issued in favor of the applicant pursuant to the applicable fee schedule.

Fee Schedule

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.)

The EIP is a New York resident and the medical services at issue were provided in New Jersey in an Ambulatory Surgery Center (ASC).

New York State Department of Financial Services Thirty Third Amendment to 11 NYCRR 68 (Insurance Regulation 83) which applies to health services performed outside New York State was effective January 23, 2018. Pursuant to this amendment an analysis of both the New York and New Jersey fee schedules is necessary to determine the appropriate fee schedule.

The issue here is whether anesthesia services are separately reimbursable when performed at an ASC in New Jersey.

NJAC 11:3-29.5 of the New Jersey Fee Schedule which governs reimbursement of Ambulatory Surgery Center fees states in pertinent part:

> (a) ASC facility fees are listed in Appendix, Exhibit 1, by CPT code. Codes that do not have an amount in the ASC facility fee column are not reimbursable if performed in an ASC. The ASC facility fee include services that would be covered if the services were furnished in a hospital on an inpatient or outpatient basis, including:
>
> 2 . All services and procedures in connection with covered procedures furnished by nurses, technical

personnel and others involved in the patient's care; . . .

7. Anesthesia materials, including the anesthetic itself, and any materials, whether disposable or re-usable, necessary for its administration; . . . . It is clear from subsection (a) of this section that codes that have no correlating amounts in the "ASC" column are not reimbursable if performed in an ASC.

Based on the foregoing, since there are no correlating amounts listed in the two ASC columns in the New Jersey Fee Schedule, these anesthesia services are not separately reimbursable when billed for services rendered in an ASC in New Jersey.

The applicant did not submit any documentation to refute the plain reading of the New Jersey Fess Schedule as it relates to separated reimbursement of anesthesia services for procedures treatment provided in an ASC.

Under these circumstances, the respondent has established its fee schedule defense.

Accordingly, the claim is dismissed with prejudice.

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 claim is DENIED in its entirety

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.

09/09/2024
(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:
fdec09f6a1aaad5d3e1ad6279f7c81a1

Electronically Signed

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