American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Global Surgery Center LLC (Applicant)	AAA Case No.	17-24-1340-8480
	Applicant's File No.	SS-266230
- and -	Insurer's Claim File No.	8717764010000002
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Matthew Brew, 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: Injured Party or IP

1. Hearing(s) held on 08/26/2024
   Declared closed by the arbitrator on 08/26/2024

   Joseph Padrucco, Esq. from Samandarov & Associates, P.C. participated virtually for the Applicant

   Kevin Smith, Esq. from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$8,916.04**, was AMENDED and permitted by the arbitrator at the oral hearing.

   $7443.59 per fee schedule as stipulated by the parties.

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

   The parties further stipulated to Applicant's prima facie case and to the timeliness of Respondent's denial.

   The parties also stipulated that should Applicant prevail, interest would accrue from the filing date of March 19, 2024.

3. Summary of Issues in Dispute

Applicants' assignor, hereinafter referred to as the Injured Party or "IP", is described as a then 66-yr-old male passenger of a motor vehicle involved in an accident on February 13, 2023. Subsequent to the loss, the IP sought various treatments in regard to injuries claimed to have resulted from the underlying MVA.

In this case, Applicant was initially seeking reimbursement in the amount of $8916.04 in regard to its bill for the facility fees associated with the IP's right knee surgery performed on January 8, 2024. However, during argument the parties stipulated to amend that amount to $7443.59 per fee schedule/agreement between parties.

Respondent received Applicant's bill on January 20 and denied same on February 7, 2024. Reimbursement was denied based upon the results of an IME conducted by Dr. Pierce Ferriter, MD, conducted on July 14, 2023. As a result of that exam, all further orthopedic treatment was denied as of July 28, 2023.

In response to the IME, Applicant relies in part upon a rebuttal from Dr. John Mitamura, MD, dated June 25, 2024. Dr. Mitamura performed the surgery. Applicant further relies upon the submitted records and the arguments of counsel.

It is important to note that during argument, Respondent's counsel maintained that only $2,567.81 of available coverage remains from under the subject policy of insurance. Thus, counsel provides that any award issued in favor of Applicant cannot exceed the amount remaining coverage.

Notably, all fee issues were resolved by stipulation. Finally, I note that the parties further stipulated to Applicant's prima facie case and to the timeliness of Respondent's denial.

Thus, the issue to be decided in this case is whether Respondent established and lack of medical necessity defense in regard to the facility fees associated with the IP's right knee surgery performed on January 8, 2024?

If answered in the negative, whether Respondent established and sustained its "near policy exhaustion" defense?

4. Findings, Conclusions, and Basis Therefor

In comparing all the relevant evidence submitted by the parties as contained in the electronic file maintained by the American Arbitration Association, and in consideration of the oral arguments presented by each party, ***I find in favor of Applicant in the amount of $2,567.81 with the remainder of its claim being denied in its entirety.***

Upon stipulating to the Applicant's prima facie case, the burden shifted to the Respondent to come forward with enough evidence to rebut the presumption of medical necessity that attached to the Applicant's bills. When, as in the present case, the claim or claims are denied based upon the results of an independent medical examination, the conclusions of the doctor must be supported by a sufficiently detailed factual basis and medical rationale. The failure to provide such support will result in the report having little to no probative value. When a Respondent carrier establishes a defense based on a lack of medical necessity, the burden shifts back to the provider who then must refute the findings of the IME doctor and come forward with its own evidence of medical necessity.

After reviewing applicable records and performing his examination, Dr. Ferriter concluded that no further orthopedic treatment was necessary in regard to this IP.

During his examination, Dr. Ferriter noted the IP's complaints of pain in his head, neck, lower back, bilateral shoulders, and bilateral knees. He further provided that the IP advised that his symptoms have improved since the accident.

Objectively, the exam was mostly unremarkable except for diminished range of motion in the IP's left shoulder. Ranges of motion in the other afflicted areas were within normal limits. Further, there was no evidence of spasm or tenderness upon palpation. Moreover, all objective orthopedic testing was negative.

In regard to the right knee, Dr. Ferriter maintained that there was no evidence of any heat, swelling, effusion, erythema or crepitus appreciated. There was also no complaint of any tenderness upon palpation and all objective testing of the knee was negative. Further, there was no Varus/Valgus Deformity and the knee was stable on Varus/ Valgus Stress. Range of motion was normal, quadriceps and hamstring strength testing was 5/5, and there was no atrophy or chondromalacia present on palpation of the patella.

Dr. Ferriter also noted that he had reviewed the right knee MRI from March 2, 2023. The Impression was *"complex" tear of the body and posterior horn of the medical meniscus; tear and sprain of the MCL; Increased signal of the ACL indicating a sprain; small joint effusion; 4cm popliteal cyst".*

Regardless, Dr. Ferriter's diagnosis included "right knee sprain/strain- resolved". No orthopedic disability was documented and the IP was deemed "capable of working full time without restrictions". No further orthopedic treatment inclusive of surgery was deemed necessary.

Dr. Ferriter also provided that:

> *I have reviewed the medical records and diagnostic testing, including the MRI reports pertaining to the above diagnosed sites and findings are duly noted.*

However, there are no subjective clinical findings on today's examination to warrant the need for continued treatment for the cervical spine, thoracic spine, lumbar spine, bilateral shoulders and bilateral knees.

I found Dr. Ferriter's report sufficient in terms of establishing- at least prima facie- Respondent's lack of medical necessity defense. It appears Dr. Ferriter performed a thorough examination which was mostly unremarkable. This was especially true in regard to the IP's right knee.

Further, his ultimate conclusion was supported by "a sufficiently detailed factual basis and medical rationale". Carle Place Chiropractic v. New York Central Mut. Fire Ins Co., 19 Misc.3d 1139(A), 866 N.Y.S.2d 90 (Table). The burden therefore shifted to Applicant to refute the IME findings and establish through its own evidence the medical need for the underlying left knee surgery.

In response to IME and in support of its claim, Applicant relies in part upon a rebuttal from Dr. John Mitamura, MD, dated June 25, 2024. Dr. Mitamura performed the surgery. Applicant further relies upon the submitted records and the arguments of counsel.

In his rebuttal, Dr. Mitamura provided a history of his patient's condition and treatment. He also discussed the IME findings and explained why he disagreed with Dr. Ferriter's conclusions. Dr. Mitamura also stated why, in his opinion, the underlying related right knee surgery was medically necessary in this case.

In part, Dr. Mitamura discussed the various positive MRI findings of the right knee performed on March 2, 2023. He argued that "despite physical therapy, the patient had no complete relief in his complaints of right knee pain".

Dr. Mitamura also referenced an exam performed by Dr. Kim on March 31, 2023. At that time, the IP was complaining of 7-8/10 right knee pain. The examination of the right knee "revealed tenderness and decreased range of motion". The diagnosis was rigth knee sprain and the IP was referred for physical therapy, outcome assessment testing and a follow-up evaluation was scheduled.

On May 15 the IP presented to Dr. Kim for a follow-up evaluation. The claimant was complaining of 7/10 right knee pain. There was tenderness, decreased range of motion and the IP was recommended to continue with conservative treatment.

Dr. Mitamura continued by providing that the IP's condition failed to resolve through conservative measures. The lack of improvement coupled with the MRI findings warranted the need for the surgery according to the doctor.

Notably, the rebuttal proceeded by substantively discussing the IME and outlining the basis for Dr. Mitamura's disagreement with Dr. Ferriter in terms of the need for continued treatment including the disputed knee surgery.

Dr. Mitamura provided in part that:

> *Despite noting complaint of pain in the right knee at the time of the IME, Dr. Ferriter incredibly concluded that the patient's right knee condition has been resolved and that he does not need further treatment.*

During argument, Respondent's counsel argued that the IME was normal and that Applicant failed to provide any persuasive contemporaneous reports that would rebut Dr. Ferriter's exam. Counsel further argued that the rebuttal fails to cite to any contemporaneous report or reports that would refute the IME.

Moreover, counsel maintained that "none of the physical exam reports relied on show any objective evidence of a right knee injury. Applicant argues that the conservative treatment failed but does not provide reports beyond May of 2023".

Clearly, this matter involved conflicting expert opinions as to the need for the services at issue. Upon carefully reviewing the pertinent evidence submitted by both sides, and in contemplation of the arguments presented by the parties during the hearing, I found Respondent established, prima facie, its lack of medical necessity defense. Thus, the burden shifted to Applicant rebut Respondent's showing, and to establish by a preponderance of the evidence the medical need for the associated left knee surgery.

Based on the evidence presented in this case, in my opinion, Applicant satisfied its burden. After reviewing the applicable documents including the IME, the rebuttal and the submitted records, I ultimately found Applicant's evidence and arguments more persuasive on the issue of medical necessity.

I note that Respondent's counsel presented some very compelling arguments. Had the provided medical records failed to document continued, disabling pain to the knee the arguments pertaining to time frames and lack of contemporaneous reports as argued by Respondent would have been far more persuasive.

However, in this case, the MRI findings coupled with the records presented were enough to at least rebut the IME. Without a solid peer review or specific discussion as to the need for the surgery its, I found Applicant's position to be more persuasive.

Therefore, based on the foregoing I find in favor of Applicant in regard to the issue of medical necessity.

Policy Exhaustion/Near Policy Exhaustion

Respondent's counsel argues that in the event an award is rendered in favor of Applicant, same must be limited to reflect the amount of coverage remaining under the subject policy. Counsel maintains that an arbitrator exceeds his or her authority when rendering an award that goes beyond the contracted agreement.

In this case, Respondent submits a copy of the applicable declarations page showing that the IP was eligible for up to $50,000 in no fault/ first party benefits. Respondent further provides a pay ledger evidencing that $40,655.14 in PIP coverage had been paid as of May 22, 2024. *Notably, a more recent pay ledger was uploaded in linked matter 17-24-1342-3197 which was argued immediately after the case at bar. That ledger shows that in total, $40,905.14 in medical has been paid with a $200 deductible*.

Further, during argument Respondent's counsel referenced linked award 17-24-1336-8507. In that case, your undersigned awarded a different Applicant $6327.05 in regard to a different surgery. That award was issued approximately 12 days prior to today's hearing.

Thus, counsel argued that only $2,567.81 in coverage remains available to this Applicant.

Notably, since the date of the scheduled hearing, Respondent has not uploaded any additional evidence suggesting that the amount of available coverage has been further depleted. Nor does a review of the linked cases indicate that any further arbitration awards have been issued since August 26, 2024.

I note that Applicant did not challenge Respondent's proofs or calculation. Nor did it argue that the remaining amount of basic PIP coverage exceeds the $2567.81 argued by counsel.

Rather, Applicant's cited Alleviation and argued that when the disputed bill became "overdue", money was still available under the applicable policy which would have covered the entirety of Applicant's claim. Therefore, according to counsel, Applicant is entitled to the amended amount of reimbursement in regard to the disputed billing. See Alleviation v. Allstate, 2017 NY Slip Op 27097 (App. Term, 2nd Dept. 2017).

Applicant's reliance upon the holding in Alleviation is unavailing. I am not bound by the holding in that case, nor am I persuaded by its reasoning. Generally, coverage cannot be created where none exists in the first instance. Further, in the opinion of the undersigned, there is no provision within the enumerated powers of a no fault arbitrator to create coverage under any policy of insurance or under any circumstance. Once the policy limits were reached and the full amounts contracted thereunder were paid, Respondent's obligations under the policy ended. It is not within my purview or power to compel the carrier to pay out more than what was contemplated when the underlying contract was executed. Moreover, once benefits become exhausted, the IP no longer has any rights to assign and the assignment of benefits becomes invalid. Since Applicant "stands in the shoes of the assignor, and possesses no greater rights", Applicant is not entitled to further reimbursement beyond what the contract provides.

Reference is made to Presbyterian Hospital in the City of New York, v. Liberty Mutual Insurance Company, 216 AD2d 448 (1995), wherein the Appellate Division, 2nd Department *unequivocally provided* that:

However, where, as here, an insurer has paid the full monetary limits set forth in the policy, its duties under the contract of insurance cease (see, Champagne v State Farm Mut. Auto. Ins. Co., 185 AD2d 835, 837). The defendant's tardiness in issuing its denial of claim could not thereafter create a new policy or additional coverage in excess of the amount contracted for (see, e.g., Zappone v Home Ins. Co., 55 N.Y.2d 131; Schiff Assocs. v Flack, 51 N.Y.2d 692; Employers Ins. v County of Nassau, 141 AD2d 496).

See also Countrywide Ins. Co. v. Sawh, 272 AD2d 245 where the Appellate Division, 1st Department held that:

The arbitrators exceeded their authority in directing payment of the $2,250 at issue, as the award was in excess of the $50,000 limit of the subject insurance policy (Matter of Brijmohan v. State Farm Ins. Co., 92 NY2d 821; Matter of State Farm Ins. Co. v. Credle, 228 AD2d 191; Spears v. New York City Transit Authority, 262 AD2d 493, 494, Iv denied 94 NY2d 761). When an insurer "has paid the full monetary limits set forth in the policy, its duties under the contract cease" (Presbyterian Hospital v. Empire Ins. Co., 220 AD2d 733, 734, quoting Presbyterian Hospital v. Liberty Mutual Ins. Co., 216 AD2d 448).

Reference is also made to The New York State Insurance Department Office of General Counsel's opinion issued on July 30, 2008 which provides, in pertinent part, that "once the policy limits are exhausted, the assignment of benefits becomes ineffective (OGC Op. No. 08-07-28)". I interpret this opinion to mean that, once benefits were exhausted, the IP no longer had any rights to assign and the assignment of benefits became invalid. Thus, since Applicant "stands in the shoes of the assignor, and possesses no greater rights", Applicant is not entitled to any further reimbursement.

Reference is also made to Allstate Ins. Co. v. Demoura, 30 Misc3d 145(A) (App. Term, 1st Dept. 2011) which provides in part that:

…and an arbitrator's award directing payment in excess of the $50,000 limit of a no-fault insurance policy exceeds the arbitrator's power and constitutes grounds for vacatur of the award (see Matter of Brijmohan v State Farm Ins. Co., 92 NY2d 821, 822 [1998]; Countrywide Ins. Co. v Sawh, 272 AD2d at 245; 11 NYCRR 65-1.1).

Reference is also made to 11 NYCRR §65-4.10(a) and (a)(2) which provides that:

(a) Grounds for review. An award by an arbitrator rendered pursuant to section 5106(b) of the Insurance Law and section 65-4.4 or section 65-4.5 of this Subpart may be vacated or modified solely by appeal to a master arbitrator, and only upon one or more of the following grounds:
(2) that the award required the insurer to pay amounts in excess of the policy limitations for any element of first-party benefits; provided that, as a condition precedent to review by a master arbitrator, the insurer shall pay

> *all other amounts set forth in the award which will not be the subject of an appeal, as provided for in subsection 65-4.4 or section 65-4.5 of this Subpart.*

Reference is also made to the Matter of State Farm Insurance Co. v. Credle, 228 AD2d 191, 643 NYS2d 97 (1st Dept. 1996). Although set in the context of uninsured motorist coverage, upon vacating the underlying arbitration award the Appellate Division unambiguously stated that:

> *CPLR 7511 provides that an arbitration award should be vacated where an arbitrator exceeds the limits of his powers and the rights of the party are prejudiced. An award made in excess of the contractual limits of an insurance policy is an action in excess of authority (see, Matter of Sagona v. State Farm Ins. Co., 218 AD2d 660, 661, Matter of Mele v. General Acc. Ins. Co., 198 AD2d 731, 732).*

Further, I am more inclined to follow the holding in Harmonic Physical Therapy, P.C. v. Praetorian Ins. Co., 47 Misc.3d 137(A), 2015 N.Y. Slip Op. 50525(U) (App. Term 1st Dept. Apr. 14, 2015). In that case, the Appellate Term, 1st Dept. reasoned that subsequent to issuing a timely denial in response to a no fault claim, a carrier is permitted to continue to pay uncontested claims, judgments and arbitration awards.

Finally, what I also find compelling is that nowhere in the "priority of payment" portion of the applicable regulations is it even suggested that a carrier may be required to pay above policy limits (see 11 NYCRR §65-3.15). Further, the $50,000 of PIP coverage is mandated *by statute*. Article 51 of the Insurance Law unequivocally provides that "Basic economic loss" means, ***up to*** fifty thousand dollars per person" per accident for certain "necessary expenses". Moreover, 11 NYCRR §65-1.1 Section 1 provides that "Basic economic loss of each eligible injured person on account of any single accident *shall not exceed $50,000*, except that any death benefit hereunder shall be in addition thereto". Aside from "any death benefit", there is no provision or circumstance cited wherein a carrier is required to pay *above* that amount. There is no provision expanding "basic economic loss" beyond the $50,000 of coverage mandated and contracted for except as set forth therein. Nor does the priority of payment rule contained within the regulations require a carrier pay above the policy. Even if the regulation had, the validity would be suspect given that a regulation does not trump the plain language of a statute.

Therefore, based on the foregoing, I find in favor of Applicant in the amount of $2,567.81 with the remainder of its claim being denied in its entirety.

This decision is in full disposition of all claims for No-Fault benefits submitted before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not specifically raised at the time of hearing.

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**
	Global Surgery Center LLC	**01/08/24 - 01/08/24**	**$8,916.04**	**$7,443.59**	**Awarded: $2,567.81**
Total			**$8,916.04**		**Awarded: $2,567.81**

B. The insurer shall also compute and pay the applicant interest set forth below. 03/19/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   March 19, 2024 is the date that the arbitration is deemed to have been commenced.

   INTEREST: Pursuant to Insurance Law § 5106 (a), interest accrues on overdue no-fault insurance claims at a rate of 2% per month. A claim is overdue when it is not paid within 30 days after a proper demand is made for its payment (Insurance Law § 5106 [a]; 11 NYCRR 65.15 [g]). The Superintendent's regulation tolls the accumulation of interest if the claimant "does not request arbitration or institute a lawsuit within 30 days

after receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations" (11 NYCRR 65-3.9 [c]). The Superintendent has interpreted this provision to mandate that the accrual of interest is tolled, regardless of whether the particular denial at issue was timely. That interpretation was upheld by the Court of Appeals in LMK Psychological Servs, P.C. v. State Farm Mut. Auto. Ins. Co., 2009 NY Slip Op 02481 (April 2, 2009). Where no denial of claim is issued in response to a proper demand for payment, the insurer does not benefit from the tolling provision and interest will accrue from the date 30 days after the proper demand for payment is made. Interest that accrues when a denial of claim is not issued within 30 days after the proper demand for payment is made will be tolled upon the issuance of a denial of claim, although such denial is untimely, and the failure to request arbitration or institute a lawsuit within 30 days after receipt of that denial of claim form.

C. Attorney's Fees

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

For cases filed after February 4, 2015, the attorney's fee is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4. The attorney's fee shall be limited as follows: 20% of the total amount of first-party benefits and any addition first-party benefits, plus interest thereon, for each applicant per arbitration or court proceeding, subject to a maximum fee of $1,360. If the nature of the dispute results in an attorney's fee that could be computed in accordance with the limitations prescribed in both subdivision (c) and this subdivision, the higher attorney's fee shall be payable.

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 FL
SS :
County of Hillsborough

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

09/16/2024
(Dated)

Matthew Brew

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:
8d07dd9c09975b5f637e9080369a85ce

Electronically Signed

Your name: Matthew Brew
Signed on: 09/16/2024