American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Interventional Spinecare (Applicant)	AAA Case No.	17-24-1342-0407
	Applicant's File No.	177572
- and -	Insurer's Claim File No.	8738928810000003
	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 09/06/2024
   Declared closed by the arbitrator on 09/06/2024

   Michael Spector , Esq. from The Odierno Law Firm P.C. participated virtually for the Applicant

   Diana Gonzalez from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$3,644.65**, 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 55 year old EIP reported involvement in a motor vehicle accident on August 16, 2022; claimed related injury and underwent injections provided by Elizabeth Baron, PA on August 15, 2023 and September 25, 2023.

   The applicant submitted a claim for these medical services, payment of which was denied timely denied by the respondent based on the IME of the EIP by Michael Tawfellos, M.D. which was performed on July 8, 2023. The IME cut-off was effective on July 22, 2023.

The bill for date of service August 15, 2023 was also denied on the grounds that the bill was not received within 45 days of the date of service.

The respondent also asserted a fee schedule defense.

The issues to be determined at the hearing are:

Whether the applicant sustained its burden to establish a *prima facie* case of entitlement to no-fault benefits for the bill for services rendered on August 15, 2023.

Whether the respondent established that the medical services provided by the applicant 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 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.

Applicant's *prima facie* entitlement to no fault benefits for date of service August 15, 2023

It is well settled that an applicant establishes its *prima facie* showing of entitlement to No-Fault benefits by submitting evidentiary proof that the prescribed statutory billing forms had been mailed, received by the respondent and that payment of no fault benefits were overdue. See Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D. 3d 742, 774 N.Y.S.2d 564 (2d Dept. 2004.)

The applicant has not met its initial burden to establish that the "prescribed statutory billing forms had been mailed and received by the respondent" and therefore did not establish with evidentiary proof its *prima facie* showing that the bill at issue was even mailed.

Under these circumstances, the burden did not shift to the respondent to establish that it was not received.

Accordingly, the claim for services rendered on August 15, 2023 in the amount of $496.23 is dismissed with prejudice.

Medical Necessity

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 medical evidence must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review 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 medical practice as a medical rationale for his/her findings; and 3) the peer review report fails to provide 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.)

To support its contention that the physical therapy services provided to the EIP were not medically necessary, the respondent relied upon the report of the independent medical examination of the EIP by Dr. Tawfellos, which was objectively negative and unremarkable. Range of motion was determined with the assistance of a goniometer. The report presents a factually sufficient, cogent medical rationale in support of respondent's lack of medical necessity defense. Dr. Tawfellos performed a complete and comprehensive examination of the EIP which did not identify any objective positive findings and determined that his injuries were resolved.

Based upon the physical examination and medical records reviewed, Dr. Tawfellos determined that despite his subjective complaints, the EIP was not disabled and that he could perform his activities of daily living and working without restrictions. It was Dr. Tawfello's opinion that there was no medical necessity for further anesthesia/pain management, physical therapy, massage therapy, surgery, prescription medication, injections, diagnostic testing, durable medical equipment, household help or special transportation.

Respondent has factually demonstrated that the services provided by the applicant were not medically necessary. Accordingly, the burden now shifts to the applicant, who bears the ultimate burden of persuasion. See Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006.)

In response to the report of the physical examination of the EIP by Dr. Tawfellos, the applicant relied upon the submissions, including evaluations on June 12, 2023 and July 10, 2023 by Elizabeth Baron, PA-C which documented subjective complaints of pain in the left shoulder and significant spasm and tenderness with a diagnosis of lumbago, myofascial pain, cervical herniated disc and degenerative disc disease.

The medical records also document that the EIP underwent trigger point injections on June 12, 2023 and September 25, 2023.

The applicant documented sufficient contemporaneous objective findings that warranted continued treatment after the IME cut-off date and has met the burden of persuasion in rebuttal. The medical records submitted meaningfully address the arguments that are raised in the IME report and are sufficient to overcome the burden of production established by the respondent.

Based on the foregoing, the respondent has failed to establish that the services provided on September 25, 2023 were not medically necessary.

Therefore, an award for the services rendered on September 25, 2023 will be issued in favor of the applicant pursuant to the appropriate fee schedule.

Fee Schedule

At the hearing the respondent argued that the charges for the services provided to the EIP on September 25, 2023 did not conform to the appropriate fee schedule.

The entire claim was denied based on an independent medical examination performed by Dr. Tawfellos. I have already determined that the respondent did not establish its defense of a lack of medical necessity.

The only issue remaining to be determined is the respondent's fee schedule defense.

The applicant billed a total of $3,148.42 for the medical services rendered by a PA on September 25, 2023. This included $127.41 for an office visit; $131.01 for trigger point injection; $2,880.00 for J3301 and $10.00 for J2001injection medication.

Pursuant to the appropriate fee schedule the charges for the office visit and injection should have been billed at 80% since they were provided by a PA. The total reimbursable amount for these services is $206.74.

The applicant did not submit any documentation to refute the plain reading of the New York Workers' Compensation Medical fee schedule for these charges.

The respondent also argued that the injection medication was overbilled. However, no invoice was submitted for these charges and the respondent did not serve a verification request for an invoice.

Under these circumstances, the respondent established its fee schedule for the office visit and injection, but did not establish its fee schedule defense for the remaining charges.

Accordingly, the applicant is awarded $3,096.74 for the office visit and injection on September 25, 2023 and the remainder of the claim is dismissed with prejudice. 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**	**Status**
	Interventional Spinecare	**08/15/23 - 09/25/23**	**$3,644.65**	**Awarded: $3,096.74**

Total	**$3,644.65**	**Awarded: $3,096.74**

B. The insurer shall also compute and pay the applicant interest set forth below. 03/28/2024 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.

09/18/2024
(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:
3f04ae38510ca8483550559dc8fb930a

Electronically Signed

Your name: Anne Malone
Signed on: 09/18/2024