

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Triborough ASC
(Applicant)

- and -

Maya Assurance Company
(Respondent)

AAA Case No. 17-24-1331-7958

Applicant's File No. 00126910

Insurer's Claim File No. 2-231788-N01

NAIC No. 36030

ARBITRATION AWARD

I, Melissa Regina LoFurno-Braxton, 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: SC

1. Hearing(s) held on 09/09/2024
Declared closed by the arbitrator on 09/18/2024

Sasha Hockman, Esq. from Drachman Katz, LLP participated virtually for the Applicant

Bryan Visnius, Esq. from De Martini & Yi, LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$4,544.92**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The Parties stipulated to Prima Facie.

3. Summary of Issues in Dispute

The within award is based upon this arbitrator's review of the record as well as oral argument at the time of the hearing of this matter.

The claimant in this case is a 46-year old male hereinafter "SC", who was a driver at the time of the accident that occurred on 02/20/23. Following the accident, SC suffered injuries which resulted in the claimant seeking treatment. SC came under the care of

Applicant for right ankle surgery performed on 09/28/23. Respondent denied the surgery based on the negative IME performed by Dr. Hugh Selznick on 06/20/23. Respondent denied all benefits effective 07/05/23.

ISSUE:

Whether the surgery herein was medically necessary?

Whether Applicant billed in excess of the Fee Schedule?

4. Findings, Conclusions, and Basis Therefor

MEDICAL NECESSITY

Where an insurer asserts that the medical services at issue were medically unnecessary, the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. *A.B. Medical Services, PLLC v. Geico Insurance Co.*, 2 Misc. 3d 26, NY Slip Op 23949 (N.Y. App. Term 2003). 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 *Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance*, 20 Misc.3d 144(A), 873 N.Y.S.2d 238 (App. Term 2d & 11th Dists. 2008).

Where the insurer presents sufficient evidence to establish a defense based on lack of medical necessity, the burden shifts to the medical provider, which must then present its own evidence of medical necessity. *I & B Surgical Supply aao Jean Elie v. NY Central Mut. Fire Ins.Co.*, 16 Misc.3d 4, NY Slip Op 27159 (App Term, 2nd & 11th Jud Dists 2007); *West Tremont Medical Diagnostic PC v. Geico*, 13 Misc.3d 131, 824 N.Y.S. 2d 759 (2006).

Respondent denied Applicant's claim based on the IME report of Dr. Hugh Selznick dated 06/20/23. At the time of IME, Dr. Selznick measured full range of motion in the lumbar spine in all planes. Orthopedic testing was noted to be negative. There was no tenderness to palpation noted. Following the physical examination, Dr. Selznick concluded that the claimant did not require additional orthopedic benefits. Based upon the foregoing, Respondent has set forth a cogent medical rationale in support of its defense.

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

In opposition to the IME report, Applicant has submitted numerous medical records for review including the report dated 06/02/23. A review of the aforementioned report reveals decreased range of motion of the cervical spine in extension and decreased range of motion in the lumbar spine in extension.

Upon review of the aforementioned medical records, I find the medical records submitted by Applicant contradict the findings of Dr. Selznick's IME as they present factually sufficient rebuttal evidence demonstrating further treatment was medically necessary. The aforementioned records contain contemporaneous positive objective findings through provocative testing, and as such Applicant has met the burden of persuasion in rebuttal.

Based on the aforementioned, Applicant is awarded the claim herein.

I now turn to the issue of Fee Schedule to determine the proper amount of reimbursement that Applicant is entitled to receive.

FEE SCHEDULE

Respondent argues that Applicant has billed in excess of the Fee Schedule. Applicant counters that Respondent has failed to sustain its burden with regard to its defense based on Fee Schedule.

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See *Robert Physical Therapy, PC v. State Farm Mutual Auto Ins. Co.*, 2006 NY Slip Op 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006).

If Respondent fails to demonstrate by competent evidentiary proof that an Applicant's claims were in excess of the appropriate fee schedules, Respondent's defense of non-compliance with the appropriate fee schedules cannot be sustained. See *Continental Medical PC v. Travelers Indemnity Co.*, 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1 Dept, per curiam, 2006).

In that regard, an insurer's unilateral decision to re-code or change a medical provider's billed CPT codes, to reimburse disputed medical services at a reduced rate, or to deny a claim in its entirety, is ineffectual when unsupported by a peer review report or by other proof setting forth a sufficiently detailed factual basis and medical rationale for the code changes, fee reductions and denials. See *Amaze Medical Supply v. Eagle Insurance Company*, 2 Misc.3d 128A (App Term 2d and 11 Jud Dist 2003).

If an insurer presents sufficient evidence to substantiate its reduction of a bill pursuant to the Worker's Compensation Medical Fee Schedule, the burden shifts to the medical provider to rebut the carrier's fee schedule interpretation. See *Natural Acupuncture Health, PC v. Praetorian Ins. Co.*, 30 Misc.3d 132A (App Term 1 Dept st 2011).

It must be stated that a review of Respondent's submission fails to reveal an affidavit in support of its Fee Schedule defense for this arbitrator's review. Pursuant to the above case law, the burden of proving fee schedule falls squarely on the shoulders of Respondent. In this case, Respondent has failed to sustain its burden with regard to fee schedule.

Respondent has failed to provide sufficient proof in the form of any affidavit in support from someone with expertise in the area of fee schedule or coding that would provide a sufficiently detailed factual analysis with regard to the appropriate amount to be reimbursed for the services at issue.

As Respondent has failed to establish its defense based on Fee Schedule, Applicant will awarded the claim as billed.

Based on the aforementioned, Applicant is awarded \$4,544.92.

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
	Triborough ASC	09/28/23 - 09/28/23	\$4,544.92	Awarded: \$4,544.92

Total	\$4,544.92	Awarded: \$4,544.92
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- B. The insurer shall also compute and pay the applicant interest set forth below. 01/09/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest shall be computed from the AR1 filing date at the rate of 2% per month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9 (c).

C. Attorney's Fees

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

Respondent shall pay the Applicant attorney's fees in accordance with 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 NY

SS :

County of Suffolk

I, Melissa Regina LoFurno-Braxton, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

10/09/2024
(Dated)

Melissa Regina LoFurno-Braxton

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:
01dfd21b50981b079182a995a9293ac8

Electronically Signed

Your name: Melissa Regina LoFurno-Braxton
Signed on: 10/09/2024