

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Island Ambulatory Surgery Center LLC  
(Applicant)

- and -

Progressive Casualty Insurance Company  
(Respondent)

AAA Case No. 17-24-1346-2663

Applicant's File No. 00132450

Insurer's Claim File No. 232396136

NAIC No. 11851

**ARBITRATION AWARD**

I, Melissa Melis, 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: patient

1. Hearing(s) held on 10/16/2024  
Declared closed by the arbitrator on 10/16/2024

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

Jean Schabhuttl, Esq. from Progressive Casualty Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$10,593.29**, was AMENDED and permitted by the arbitrator at the oral hearing.

The amount of the claim was reduced to \$7898.71 in accordance with the New York State Workers Compensation fee schedule.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The patient, a 53 year old female passenger was involved in an automobile collision on June 3, 2023. The Applicant was the facility where a lumbar discectomy was performed on the patient on February 23, 2024. The claim of payment was denied "...based upon the results of a medical examination." The issue is whether or not the Applicant is entitled to No-fault benefits.

#### 4. Findings, Conclusions, and Basis Therefor

The Applicant is seeking reimbursement for the facility fee for the lumbar discectomy performed on the patient on February 23, 2024. This hearing was conducted using the documents contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association. All documents contained in the ECF are made part of the record of this hearing and my decision was made after a review of all relevant documents found in the ECF as well as the arguments presented by the parties during the hearing.

In accordance with 11 NYCRR 65-4.5(o) (1), an arbitrator shall be the judge of the relevance and materiality of the evidence and strict conformity of the legal rules of evidence shall not be necessary. Further, the arbitrator may question or examine any witnesses and independently raise any issue that Arbitrator deems relevant to making an award that is consistent with the Insurance Law and the Department Regulations.

The Applicant submitted a bill to the Respondent for payment. The Applicant established its prima facie entitlement to No-fault benefits by proof of the submission to the Respondent of a claim form, proof of the fact and the amount of the loss sustained, and proof either that the Respondent had failed to pay or deny the claim within the requisite 30-day period, or that the Respondent had issued a timely denial of claim that was conclusory vague or without merit as a matter of law. *Ave T MPC Corp. v Auto One Ins. Co.*, 32 Misc.3d 128 (A), 2011 NY Slip Op 51292 (U), 2011 WL 2712964 (App. Term 2d, 11th & 13th Dists., July 5, 2011).

The claim of payment was denied "based upon the results of a Medical Examination." Applicant's counsel argued that these denials failed to properly notify the Applicant of the basis for the denial and are defective in accordance with the holding in *General Accident Ins. Group v. Cirucci*, 46 N.Y.2d 862, 864, 414 N.Y.S.2d 512, 387 N.E.2d 223 (1979). She stated that the patient may have undergone multiple independent medical examinations and the Respondent failed to apprise the Applicant the name of the medical examiner and the specialty upon which the denial was based. It is well settled that a proper denial of claim must promptly apprise the claimant with a high degree of specificity of the grounds on which the denial is based on. *Nyack Hospital v. State Farm Mutual Automobile Ins. Co.*, 11 A.D.3d 664, 664, 784 N.Y.S.2d 136, 137 (2d Dept. 2004) (citing *General Accident Ins. Group v. Cirucci*, 46 N.Y.2d 862, 864, 414 N.Y.S.2d 512, 514 (1979)). I find the specific denials did not properly apprise the Applicant with a high degree of specificity of the ground upon which the denial is based on since did not specify the date of the IME, the examiner that performed the IME, the specialty of the IME or the effective cut-off date. The denial language is overly vague with the possibility of confusion and

prejudice especially if the record contains multiple different IME reports. As noted by Arbitrator Allison Schimel in *Total Wellness & Medical Health, PC v. Progressive*, AAA#: 17-21-1208-2054, "Respondent's generic language substantially impairs, if not entirely frustrates, the trier-of-fact's ability to identify whether the medical examination report submitted in evidence is in fact the report upon which the insurer's denials are predicated." The burden is on Respondent to state with a "high degree of specificity" upon what grounds the denial for each claim was based. In this case, Respondent did advise the Applicant that No-fault benefits were denied based on the medical examination by Dr. Pierce Ferriter but did not base the denial of benefits for each of the bill at issue on this particular independent medical examination. The Respondent did not give specificity with regard to the denial of payment for these particular bills. Since the Respondent did not meet its burden, I find that the disputed denials were improper and unsubstantiated.

The remaining issue is what is the correct fee schedule amount for the services billed. Applicant and Respondent both submitted affidavits from certified professional coders.

I take judicial notice of the Worker's Compensation Fee Schedule. See, *Kingsbrook Jewish Medical Center v. Allstate Insurance Company*, 61 AD 3d 13, 20 (2nd Dept., 20019; *LVOV Acupuncture PC v Geico Ins Co.*, 32 Misc. 3d 144 (A) 2011 NY Slip Op 51721 (U) (App Term 2nd, 11th and 13th Jud. Dists. 2011). *Natural Acupuncture Health PC v. Praetorian Insurance Company*, 30 Misc. 3d 132 (A), 2011 NY Slip op 50040 (U), (App. Term 1st Dept. 2011). I also take judicial notice of the 2008 and 2013 CPT Assistant. The official New York Workers Compensation Medical Fee Schedule, promulgated by the chair of the Workers Compensation Board, directs users to "refer to the CPT book for explanation of coding rules and regulations not listed in the schedule," and the CPT book, in turn, expressly makes reference to the CPT Assistant newsletter; thus, the CPT Assistant newsletter must be considered in rendering an arbitration award when the insurer states it is relying on it in making partial payment. *Matter of Global Liberty Insurance Company v. McMahon*, 2019 NY Slip Op 03692 (1st Dept., 5/9/19).

I find based on the evidence and the fee schedule that the Respondent's certified professional coder was credible and the Applicant is entitled to \$5292.93 for the facility fee for the lumbar discectomy performed on the patient on February 23, 2024.

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
	Island Ambulatory Surgery Center LLC	02/23/24 - 02/23/24	\$10,593.29	\$7,898.71	Awarded: \$5,292.93
Total			\$10,593.29		Awarded: \$5,292.93

B. The insurer shall also compute and pay the applicant interest set forth below. 05/02/2024 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

11 NYCRR 65-3.9(a) provides, in pertinent part, "All overdue mandatory and additional personal injury protection benefits due an applicant or assignee shall bear interest at a rate of two percent per month, calculated on a pro rata basis using a 30 day month..." Since this claim was timely denied but the action was not instituted until 30 days after the date of the denial, interest is due at a rate of 2% per month, simple from the date after the date of filing of this arbitration until the date of payment of this award.

C. Attorney's Fees

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

The insurer shall pay the applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(d) which states: "For all other disputes subject to arbitration or court proceedings, subject to the provisions of subdivision (a) of this section, the attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon for each applicant per arbitration or court proceeding, subject to a maximum fee of \$1,360..."

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

10/24/2024  
(Dated)

Melissa Melis

### **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:**  
a89191e40107b531177bbbc4b447e730

### **Electronically Signed**

Your name: Melissa Melis  
Signed on: 10/24/2024