

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Brooklyn Medical Practice, PC
(Applicant)

- and -

American Transit Insurance Company
(Respondent)

AAA Case No. 17-24-1350-6572

Applicant's File No. AR24-24197

Insurer's Claim File No. 1109835-01

NAIC No. 16616

ARBITRATION AWARD

I, Marcelo Vera, 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 10/22/2024
Declared closed by the arbitrator on 10/22/2024

On Submission from The Beynenson Law Firm, PC participated by written submission for the Applicant

Erisa Ahmedi, Esq. from American Transit Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$1,331.68**, 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 arbitration arises out of treatment to the EIP, JR, a male, involved in a motor vehicle accident on February 25, 2022. Applicant seeks reimbursement in the amount of \$1331.68 for services performed March 02, 2022 to October 17, 2023. Addressing dates of service March 2, 2022 to July 27, 2022 Respondent has issued partial payment and denied the remainder billed under based on the relative value unit cap and the defense of concurrent care and fee schedule. Addressing dates of service January 06, 2023 to October 17, 2023 Respondent has denied the claim based upon the independent medical examination performed on December 19, 2022 by Eric Roth, M.D.

4. Findings, Conclusions, and Basis Therefor

My decision is based on the arguments of representatives for each party as well as those documents contained in the electronic file maintained by the American Arbitration Association. I have reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

It is Applicant's prima facie obligation to establish its entitlement to payment for each service for which reimbursement is sought. It is well settled that a health care provider establishes its prima facie entitlement to payment as a matter of law by proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law § 5106 a; *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]; *Amaze Med. Supply v. Eagle Ins. Co.*, 2 Misc. 3d 128A, 784 N.Y.S. 2d 918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]). Herein, applicant established its prima facie entitlement to first party no-fault benefits by proof that it submitted a claim setting forth the fact and amount of the loss sustained and that payment of no-fault benefits was overdue.

RVU

Respondent argues that the fees charged by Applicant exceeded the relative value units per day, as treatment was also provided by a different provider, on overlapping dates of service, and the codes reported by both providers are among those listed in the Workers' Compensation Medical Fee Schedule, Physical Medicine Ground Rule 11 or the Workers' Compensation Chiropractic Fee Schedule, Physical Medicine Ground Rule 3 as being limited to 8 relative value units (RVU) per individual date of service.

It must be noted that ground rule 11 provides:

When multiple physical medicine procedures and/or modalities are performed on the same day, Reimbursement is limited to 8.0 units or the amount billed, which ever is less. The following codes represent the physical medicine procedures and modalities subject to this rule:

97010 97012 97014 97016 97018 97022

97024 97026 97028 97032 97033 97034

97035 97036 97039 97110 97112 97113

97116 97124 97139 97140 97150 97530

97535 97537 97542 97760 97761

Ground Rule 3 of the Physical Medicine Section of the Workers Compensation Chiropractic Fee Schedule reads: When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 8.0 RVUs (Relative Value Units) or the amount billed, which ever is less

The Following codes represent the physical medicine procedures and modalities subject to this rule:

97010 97012 97014 970265 97028 97032

97033 97034 9735 97039 97110 97112

97113 97116 97124 97139 97530 98940

98941 98942

In the matter at hand the codes reported by both providers are included on the ground rules listed above, as such the reimbursement to both a Chiropractor and physical therapist treating the same parts of the body during overlapping dates of services would be limited to 8.0 relative value units. The Workers' Compensation Board has addressed this very issue:

If a claimant is treating with a chiropractor and physical therapist and they both bill modality CPT code(s) that are subject to the RVU per day limitations in the Fee Schedule, both may not be paid. The carrier may object to the bills based on concurrent care. the treating providers may request arbitration, and the arbitration panel will decide if the services rendered were duplicate. If the physical therapist and the chiropractor are providing different treatments, it would not be considered concurrent care.

The Board has further elaborated and stated as follows:

The proposed changes to the CFS will limit the number of relative value units (RVU) that a chiropractor can bill in one visit. However, pursuant to part 324 of Title 12 NYCRR which will take effect for dates of service on or after December 1, 2010, chiropractors must treat injuries

to the neck and mid and low back according to the treatment guidelines for those body part, which set the number of manipulations and modalities for particular injuries to the neck and back. If a claimant is treating with a chiropractor and a physical therapist and they both bill the same CPT for modalities in the same body part for the same day, the insurance carrier is not required to pay both bills.

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 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006 N.Y. Misc. LEXIS 1519 (Civil Ct, Kings Co. 2006). See also, *Power Acupuncture PC v. State Farm Mutual Automobile Ins. Co.*, 11 Misc.3d 1065A, 816 N.Y.S.2d 700, 2006 NY Slip Op 50393U, 2006 N.Y. Misc. LEXIS 514 (Civil Ct, Kings Co. 2006). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance 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, 1st Dep't, per curiam, 2006).

Respondent's counsel argues that the Respondent paid multiple other providers, on concurrent dates of service. As such since the EIP was receiving concurrent physical therapy treatments on the same dates of service, it was entitled to reduce reimbursement to Applicant once the maximum reimbursement of units had been achieved.

Applicant's counsel points out the record is devoid of any documentation supporting the Respondent's denials. After a thorough review of the documentation uploaded and denying the Respondent's request to upload documentation post hearing. I find that Respondent has failed to provide evidence establishing that it paid eight relative value units of the prescribed procedures and modalities subject to Physical Medicine Ground Rule 11 of the New York Workers' Compensation Medical Fee Schedule.

Applicant has acknowledged payments on the above dates of service. The unpaid remainder of the claims is awarded.

Medical Necessity

If an insurer asserts that the medical test, treatment, supply or other service was 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. (See *A.B. Medical Services, PLLC v. Geico Insurance Co.*, 2 Misc. 3d 26 [App Term, 2nd & 11th Jud Dists 2003]; *Kings Medical Supply Inc. v. Country Wide Insurance Company*,

783 N.Y.S. 2d at 448 & 452; *Amaze Medical Supply, Inc. v. Eagle Insurance Company*, 2 Misc. 3d 128 [App Term, 2nd and 11 Jud Dists 2003]).

Respondent asserts that the treatments post IME were timely denied based upon the independent medical examination performed by Eric Roth, M.D. An IME report asserting 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. *Carle Place Chiropractic v. New York Central Mut. Fire Ins Co.*, 19 Misc.3d 1139(A), 866 N.Y.S.2d 90 (Table), 2008 N.Y. Slip Op. 51065(U), 2008 WL 2228633 (Dist. Ct., Nassau Co., May 29, 2008, Andrew M. Engle, J.). An IME report must set forth a factual basis and medical rationale for the conclusion that further services are not medically necessary. E.g., *Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance*, 20 Misc.3d 144(A), 873 N.Y.S.2d 238 (Table), 2008 N.Y. Slip Op. 51863(U), 2008 WL 4222084 (App. Term 2d & 11th Dists. Sept. 3, 2008). The Case law states that the 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. *Bronx Expert Radiology, P.C. v Travelers Ins. Co.*, 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006).

In support of its contention further treatment was not medically necessary, respondent relies upon the IME examination performed by Eric Roth, M.D. on December 19, 2022. Dr. Roth's report details the history relating to the accident and EIP's treatment to date as related by the claimant. The physical examination report indicates all findings were objectively negative and unremarkable, range of motion was within normal limits and orthopedic testing was noted to be negative. Dr. Roth indicated conditions in spine were resolved and status post left shoulder arthroscopic surgery resolved. Dr. Roth concluded there was no need for further treatment.

Where the Respondent presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden then shifts to the Applicant which must then present its own evidence of medical necessity. [see *Prince, Richardson on Evidence* §§ 3-104, 3-202 [Farrell 11th ed]], *Andrew Carothers, M.D., P.C. v. GEICO Indemnity Company*, 2008 NY Slip Op 50456U, 18 Misc. 3d 1147A, 2008 N.Y. Misc. LEXIS 1121, *West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co.* 13 Misc.3d 131, 824 N.Y.S.2d 759, 2006 NY Slip Op 51871(U) (Sup. Ct.

I find that Respondent's IME report meets the above burden and I will look to Applicant to refute the conclusions reached by the IME doctor After reading all the submissions including the medical records and the IME report, I find that Applicant has set forth sufficient evidence to refute the conclusion reached by Dr. Roth

Applicant argues the evidence demonstrate the EIP was still experiencing discomfort associated with injuries initially sustained in the motor vehicle accident of February 25, 2022 at the time of the IME. Applicant's proof consists of medical records that are contemporaneous to the IME, specifically the reports dated November 10, 2022 by Brooklyn Medical Practice noting reductions in range of motion and positive orthopedic findings, indicating continued care is required in the form of continued physical therapy, referral to orthopedist and scheduled follow up on December 10, 2022 the record further

contains therapy daily notes contemporaneous to the IME. The evidence demonstrates the EIP's condition is ongoing supporting the contention that the EIP's condition had not resolved and the ongoing treatment was medically necessary at the time the EIP underwent the IME.

As per the evidence before me, I find the Applicant's proof is sufficient to overcome the showing made by the IME doctor. I feel bound to defer to the opinion of the Applicant, as treating provider rather than the opinion of the Respondent's IME consultant. I find Applicant's assessment of the EIP's condition regarding treatment to be credible and convincing and award the claim.

Accordingly, in light of the foregoing, based on the arguments of counsel and after a thorough review and consideration of all submissions, I find in favor of the Applicant and grant Applicant's claim. This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of the 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	Status
	Brooklyn Medical Practice, PC	03/02/22 - 03/16/22	\$134.36	Awarded: \$134.36

	Brooklyn Medical Practice, PC	04/01/22 - 04/27/22	\$134.56	Awarded: \$134.56
	Brooklyn Medical Practice, PC	06/02/22 - 06/28/22	\$271.44	Awarded: \$271.44
	Brooklyn Medical Practice, PC	07/13/22 - 07/27/22	\$132.32	Awarded: \$132.32
	Brooklyn Medical Practice, PC	01/06/23 - 01/06/23	\$33.64	Awarded: \$33.64
	Brooklyn Medical Practice, PC	03/08/23 - 03/24/23	\$202.58	Awarded: \$202.58
	Brooklyn Medical Practice, PC	05/08/23 - 05/17/23	\$261.85	Awarded: \$261.85
	Brooklyn Medical Practice, PC	08/10/23 - 08/10/23	\$33.64	Awarded: \$33.64
	Brooklyn Medical Practice, PC	10/17/23 - 10/17/23	\$127.29	Awarded: \$127.29
Total			\$1,331.68	Awarded: \$1,331.68

- B. The insurer shall also compute and pay the applicant interest set forth below. 06/04/2024 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." 11 NYCRR §65-3.9(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." 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 at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009).

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) This matter was filed after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 11 NYCRR 65-4.6(d). This amendment takes into account that the maximum attorney fee has been raised from \$850.00 to \$1,360.00.

- 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 Nassau

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

11/14/2024
(Dated)

Marcelo Vera

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:
0ab2abd1b6dd8439e82837b63ba5ba4e

Electronically Signed

Your name: Marcelo Vera
Signed on: 11/14/2024