American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

MK Medical Care PC (Applicant)	AAA Case No.	17-24-1363-4422
	Applicant's File No.	173091
- and -	Insurer's Claim File No.	0307740380101035
	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 01/31/2025
   Declared closed by the arbitrator on 01/31/2025

   John Faris, Esq. from Law Offices of Eitan Dagan (Woodhaven) participated virtually for the Applicant

   Diana Gonzalez from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$5,072.88**, 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 58 year old EIP reported involvement in a motor vehicle accident on May 26, 2023; claimed related injury and underwent extracorporeal shockwave therapy (ESWT) from June 26, 2023 to October 30, 2023 and physical therapy treatment provided by the applicant from August 2, 2023 to March 20, 2024.

   The applicant submitted a claim for these medical services. Payment of the shockwave therapy provided from June 26, 2023 to October 30, 2023 was denied based on peer reviews by Michael Tawfellos, M.D. which were dated August 16,

2023, October 4, 2023 and December 26, 2023. In response, the applicant submitted a rebuttal dated January 2, 2025 by Mark Kovalevsky, M.D. one of the EIP's treating medical providers.

Payment of the claim for physical therapy treatment provided from December 14, 2023 to March 20, 2024 was timely denied by the respondent based on the IME of the EIP by Aruna Seneviratne, M.D. which was performed on November 30, 2023. The IME cut-off was effective on December 14, 2023.

The respondent also asserted a fee schedule defense for physical therapy treatment provided from August 2, 2023 to November 28, 2023 and for ESWT provided from June 26, 2023 to October 30, 2023.

The issues to be determined at the hearing are:

Whether the respondent established that the shockwave therapy provided from June 26, 2023 to October 30, 2023 and physical therapy treatment provided from December 14, 2023 to March 20, 2024 was not medically necessary.

Whether the respondent established its fee schedule defense for physical therapy treatment provided from August 2, 2023 to November 28, 2023 and ESWT provided from June 26, 2023 to October 30, 2023.

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.

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.)

IME

To support its contention that the physical therapy treatment provided to the EIP from December 14, 2023 to March 20, 2024 was not medically necessary, the respondent relied upon the report of the independent medical examination of the EIP by Dr. Seneviratne, which documented limitations of range of motion in the cervical, thoracic and lumbar spine and right shoulder. Range of motion was measured with the assistance of a goniometer. Dr. Seneviratne determined that these restrictions were due to sub-optimal effort and voluntary guarding. Although tenderness was documented, Dr. Seneviratne determined that there were no objective findings and all other tests were negative.

In Torres v Garcia, 59 A.D.3d 705, 874 N.Y.S.2d 527 (App.Div.2d Dept.), the court held that a defendant failed to meet its *prima facie* burden when its physician failed "to explain or substantiate, with objective medical evidence, the basis for his conclusion" that restrictions in range of motion due to sub-optimal effort or voluntary guarding.

Despite the findings of restricted range of motion, Dr. Seneviratne determined that cervical, thoracic and lumbar spine and right shoulder sprain/strain were resolved.

Based on the report of the independent medical examination by Dr. Seneviratne and the holding in Torres, *supra*, I find that the respondent has not factually demonstrated that the medical services provided by the applicant were not medically necessary. Accordingly, the burden does not shift to the applicant. See Bronx Expert Radiology, P.C. v. Travelers Ins. Co., 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006.)

Therefore, an award will be issued in favor of the applicant pursuant to the appropriate fee schedule.

Peer Review

To support its contention that the shockwave therapy provided by the applicant was not medically necessary, respondent relies upon the reports of the peer

reviews by Dr. Tawfellos, who reviewed the medical records of the EIP, noted the injuries claimed and the treatment rendered to her. Dr. Tawfellos considered possible arguments and justification for the need for the medical services at issue and determined that they were not warranted under the circumstances presented.

He submitted a cogent and comprehensive report in which he discussed the medical services provided and his reasons for determining that they were not medically necessary for this EIP.

Dr. Tawfellos, discussed the standard of care for shockwave therapy and noted that the efficacy of this therapy is "questionable." It was his opinion that further research is necessary to demonstrate the value of this therapy.

He specifically determined that there was no documented evidence that previously performed shockwave treatment had helped this particular EIP in pain relief. There was no indication that conservative treatment that the EIP was receiving had failed. It was his opinion, supported by relevant medical literature, that the EIP should have continued receiving conservative treatment including physical therapy, chiropractic treatment and begin acupuncture treatment before undergoing shockwave therapy.

I find that the peer review is conclusory and factually insufficient to meet the burden of rebutting the applicant's presumption of medical necessity. The respondent did not provide an adequate response to the recommendations made by the EIP's treating medical providers to establish that the medical services at issue were not medically necessary. Based on the foregoing, pursuant to Provvedere, Inc., *supra* the burden did not shift to the applicant since respondent did not meet its burden to establish lack of medical necessity.

Although it was not necessary under these circumstances, the applicant submitted a rebuttal by Dr. Kovalevsky, the EIP's treating medical provider.

Under these circumstances, the respondent has failed to establish that the applicant is not entitled to reimbursement for the claim at issue.

Therefore, an award will be issued in favor of the applicant pursuant to the appropriate fee schedule.

Fee Schedule

To prevail in its fee schedule defense, the respondent must demonstrate by competent evidentiary proof that the applicant's claims are in excess of the appropriate fee schedule. If the respondent fails to do so, its defense of noncompliance with the New York Workers' Compensation Medical Fee Schedule cannot be sustained. See Continental Medical, P.C. v Travelers Indemnity Co., 11 Misc. 3d 145A (App. Term 1st Dept. 2006.)

An insurer fails to raise a triable issue of fact with respect to a defense that the fees charged were not in conformity with the Workers' Compensation fee schedule when it does not specify the actual reimbursement rates which formed the basis for its determination that the claimant billed in excess of the maximum amount permitted. See St. Vincent Medical Services, P.C. v. GEICO Ins. Co., 29 Misc.3d 141(A), 907 N.Y.S.2d 441 (App. Term 2d, Dec. 8, 2010.)

A fee schedule defense does not always require expert proof. There are two fee schedule scenarios. The first involves the basic application of the fee codes and simple arithmetic. The second scenario involves interpretation of the codes and often requires testimony and expertise beyond that of a lay individual. I find that the fee schedule issues presented in this claim are analogous to both scenarios.

Shockwave Therapy for dates of service June 26, 2023 to October 30, 2023

The applicant billed a total of $2,801.56 ($700.39 for each date of service) for EWST on four dates of service. The respondent denied payment based on the peer review by Dr. Tawfellos. I have already determined that the respondent has not established the defense of lack of medical necessity. However, the respondent has also asserted a fee schedule defense for these medical services.

The EWST was performed on June 26, 2023 and August 14, 2023 by Dr. Kovalevsky and on September 25, 2023 and October 30, 2023 by Yevhen Musayelyan, E.S.T.

The respondent supported its fee schedule defense, with the affidavit of Crystal Russo, CPC, a certified professional coder who submitted a comprehensive review and analysis and determined, based on the applicable New York fee schedule that the correct reimbursable amount for these services performed by a physician is $700.39 which is the amount billed by the applicant for the services rendered by Dr. Kovalevsky.

However, according to Ms. Russo if EWST is not performed by a surgeon it is not reimbursable after April 1, 2019. The bills for dates of service September 25, 2023 and October 30, 2023 state that Yevhen Musayelyan E.S.T performed this procedure, therefore it is not reimbursable.

Based on the foregoing, the respondent has established its fee schedule defense for dates of service September 25, 2023 and October 30, 2023.

Therefore, the applicant is awarded $1,400.78 for services rendered for EWST on June 26, 2023 and October 30, 2023 and the remainder of the bills for these services are dismissed with prejudice.

Physical Therapy dates of service August 2, 2023 to December 6, 2023

The applicant billed a total of $2,385.47 for physical therapy treatment provided on these dates of service. The respondent made partial payment of $1,742.99 based on the appropriate fee schedule.

Pursuant to Ground Rule11 of the Physical Medicine Section of the New York Workers' Compensation Medical Fee Schedule, effective 1/1/2020 "[w]hen multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 12.0 RVUs per patient per accident or illness or the amount billed, whichever is less."

Pursuant to Ground Rule 2 of the Physical Medicine Section of the New York Workers' Compensation Medical Fee Schedule, effective 1/1/2020 the maximum number of relative value units when billing for an initial evaluation shall be limited to 18.0 units. Ground Rule 3 states that when multiple physical therapy procedures and/or modalities are performed on the same day, reimbursement is limited to 12.0 RVUs per patient per accident or illness or the amount billed whichever is less. When a patient receives acupuncture, chiropractic, physical or occupational procedures or modalities from more than one provider, the patient may not receive more than 12.0 RVUs per day per accident or illness from all providers.

The following codes represent physical medicine procedures and modalities subject to these rules:

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, 97763

In this claim, the respondent made partial payments for each date of service at issue pursuant to Ground Rule 3 of the Physical Medicine Section of the New York Workers' Compensation Medical Fee Schedule, effective 1/1/2020 and made payment for chiropractic treatment provided by Active Release Chiropractic, PC on the same dates of service for which physical therapy treatment was provided.

Based on the foregoing, the respondent has established its fee schedule defense for dates of service August 2, 2023 to December 6, 2023.

Therefore, the claim for dates of service August 2, 2023 to December 6, 2023 is dismissed with prejudice.

Physical Therapy treatment from January 23, 2024 to March 20, 2024

The applicant billed a total of $1,508.32 for physical therapy treatment provided from January 23, 2024 to March 20, 2024 for which no payment was made by the respondent.

The charges for these dates of service were billed correctly pursuant to the appropriate fee schedule.

Based on the foregoing, the respondent has not established a fee schedule defense for dates of service January 23, 2024 to March 20, 2024.

Therefore, the applicant is awarded $1,508.32 for physical therapy treatment rendered from January 23, 2024 to March 20, 2024.

Accordingly, the applicant is awarded a total of $2,909.10 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
	MK Medical Care PC	**06/26/23 - 03/20/24**	**$5,072.88**	**Awarded: $2,909.10**
Total			**$5,072.88**	**Awarded: $2,909.10**

B. The insurer shall also compute and pay the applicant interest set forth below. 09/02/2024 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.

02/10/2025
(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:
07aaf6a7d8fb6f36c23262e8eeb957aa

Electronically Signed

Your name: Anne Malone
Signed on: 02/10/2025