

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Syosset Surgicenter  
(Applicant)

- and -

Farmers New Century Insurance Company  
(Respondent)

AAA Case No. 17-24-1351-9885

Applicant's File No. 180435

Insurer's Claim File No. 7900023178-1-2

NAIC No. 21709

**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: PM

1. Hearing(s) held on 01/13/2025  
Declared closed by the arbitrator on 01/21/2025

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

Lindbergh Hnung, Esq. from Law Offices of Rothenberg & Romanek participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$7,197.04**, 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 56-year old male hereinafter "PM", who was a driver involved in a motor vehicle accident that occurred on 08/04/23. Following the accident

PM suffered injuries which resulted in the claimant seeking treatment. PM came under the care of Applicant for wrist surgery performed on 12/21/23. Applicant is the facility in which the surgery was performed. The surgery and thus the facility fee for the surgery were denied by Respondent based on the peer review report of Dr. Stuart Springer that found the surgery was medically unnecessary.

ISSUE:

Whether the surgery was medically necessary?

Whether the Applicant billed in excess of the Fee Schedule?

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

##### **MEDICAL NECESSITY**

In order to support a lack of medical necessity defense respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See, *Provvedere, Inc. v. Republic Western Ins. Co.*, 2014 NY Slip Op 50219(U) (App. Term 2nd, 11th and 13th Jud. Dists. 20140). 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 generally, *Bronx Expert Radiology, P.C. v. Travelers Ins. Co.*, 2006 NY Slip Op 52116 (App. Term 1st Dept. 2006). The Appellate Courts have not clearly defined what satisfies this standard except to the extent that "bald assertions" are insufficient. *Amherst Medical Supply, LLC v. A Central Ins. Co.*, 2013 NY Slip Op 51800(U) (App. Term 1st Dept. 2013). However, there are myriad civil court decisions tackling the issue of what constitutes a "factual basis and medical rationale" sufficient to establish a lack of medical necessity.

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 findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. See generally, *Nir v. Allstate*, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005); See also, *All Boro Psychological Servs. P.C. v. GEICO*, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012). "Generally accepted practice is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." *Nir, supra*. The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, *Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co.*, 2009 NY Slip Op 00351 (App Div 2d Dept., Jan. 20, 2009); *Channel Chiropractic, P.C. v.*

*Country-Wide Ins. Co.*, 2007 Slip Op 01973, 38 A.D.3d 294 (1st Dept. 2007); *Bronx Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co.*, 2007 NY Slip Op 27427, 17 Misc.3d 97 (App Term 1<sup>st</sup> Dept., 2007), such as by a qualified expert performing an independent medical examination, conducting a peer review of the injured person's treatment, or reconstructing the accident. *Id.*

In support of its contention that the surgery performed on 12/21/23 was not medically necessary, Respondent relies on the peer review report of Dr. Stuart Springer dated 01/25/24. Dr. Springer lists the medical records reviewed and details PM's relevant medical history. He contends that the surgery was not medically necessary. Dr. Springer states in his peer review report, with regard to the prescribing of the surgery that:

*"Right endoscopic carpal tunnel release surgery along with the associated services of Injection into the tendon or ligament were not medically necessary."*

In the instant case, 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, Bronx Expert, *supra*.

In rebuttal, Applicant provides numerous medical records for review. The medical records reveal that the claimant initially complained of right wrist pain with continued positive testing and decreased range of the wrist.

Comparing the relevant evidence presented by both parties against each other, I am persuaded by Applicant's medical documentation and defer to the Assignor's treating provider. The medical records establish that the Assignor continued to present with continued complaints of wrist pain that impacted his activities of daily living and positive findings. I find that Applicant has therefore rebutted Respondent's defense and sustained its burden of proof regarding the medical necessity of the surgery.

Given the aforementioned, Applicant is awarded the claim.

I now turn to the issue of Fee Schedule to determine the proper amount of reimbursement that Applicant would be entitled to based on Fee Schedule.

### **FEE SCHEDULE**

Respondent argues that Applicant billed in excess of the Fee Schedule and as such that Applicant is not entitled to any reimbursement. Applicant counters that Respondent has failed to meet 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 defense. *See, Robert Physical Therapy, P.C. 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). *See also, Power Acupuncture PC v. State Farm Mutual Auto 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 an Applicant's claims were in excess of the appropriate fee schedules, Respondent'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, 1 Dep't, per curiam, st 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).

In support of its position, Respondent has provided the affidavit of Ms. Mohamed Beylouni Jr., Certified Professional Coder (CPC). In said affidavit, Mr. Beylouni details and lists his credentials as aforementioned. In the affidavit, Mr. Mohamed Beylouni Jr, states that pursuant to the Fee Schedule that Applicant would be entitled to receive a maximum reimbursement amount in the amount \$3,026.24. Applicant billed the procedure under CPT code 29848. Mr. Beylouni attests that as Applicant is a facility that Applicant is subject to the EAPG and as the surgery herein falls under Group 37 that Applicant would not be entitled to any additional reimbursement over the aforementioned amount.

Based on my review of the aforementioned CPC affidavit and the supporting documentation provided by Respondent, I find that Respondent has met its burden as to its Fee Schedule defense.

The burden now shifts to Applicant to establish its burden of persuasion in rebuttal.

A review of Applicant's submission reveals that Applicant has failed to provide either an affidavit or a fee audit in rebuttal to Respondent's expert to support its billing "as is" as to the services at issue.

**Based on all of the aforementioned, I find that Applicant is entitled to be reimbursed for the services at issue based on the Fee Schedule calculations as set forth by Respondent's expert in the amount of \$3,026.24.**

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
	Syosset Surgicenter	12/21/23 - 12/21/23	\$7,197.04	Awarded: \$3,026.24
Total			\$7,197.04	Awarded: \$3,026.24

- B. The insurer shall also compute and pay the applicant interest set forth below. 06/13/2024 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.

02/12/2025  
(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:**  
da41280cde99c717c6b91ec5cec11425

### **Electronically Signed**

Your name: Melissa Regina LoFurno-Braxton  
Signed on: 02/12/2025