American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Tri-Borough NY Medical Practice PC (Applicant)	AAA Case No.	17-25-1382-3417
	Applicant's File No.	N/A
- and -	Insurer's Claim File No.	0573582580003
	NAIC No.	36447
LM General Insurance Company (Respondent)		

ARBITRATION AWARD

I, Hersh Jakubowitz, 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 07/30/2025
   Declared closed by the arbitrator on 07/30/2025

   Lee-Ann R. Trupia from Law Offices of Hillary Blumenthal LLC (Hoboken) participated virtually for the Applicant

   Melissa Testa from LM General Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$7,404.52**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The Parties stipulated that Applicant had met its prima facie burden of proof and that Respondent's denials were interposed in a timely fashion.

3. Summary of Issues in Dispute

   Applicant seeks reimbursement, along with interest and counsel fees, under the No-Fault Regulations, for the costs associated with the EIP undergoing

a right shoulder arthroscopic debridement, arthroscopic major synovectomy, arthroscopic lysis of adhesions and arthroscopic biceps tenotomy on October 22, 2024, in connection with injuries allegedly sustained by EIP in a motor vehicle accident on July 14, 2024. The payment, for performing right shoulder arthroscopic surgery and affiliated surgical procedures , was denied, following a Peer Review by Dr. Douglas Unis M.D., at Respondent's behest, as not medically necessary. The denial was timely. This decision is based upon the written submissions of counsel for the respective parties contained within the electronic case file maintained by the American Arbitration Association as well as oral argument at the hearing conducted on July 30, 2025.

4. Findings, Conclusions, and Basis Therefor

History

The dispute arises from a motor vehicle accident on July 14, 2024, in which the EIP, a then 54-year-old male was involved as a restrained driver wherein he sustained numerous injuries. He was transported by ambulance to the emergency room of New Milford Hospital, where he was evaluated, treated, had CT-scans and then released for outpatient care.

EIP consulted Dr. John McGee, D.O., on July 23, 2024 complaining of neck, back, right shoulder, left elbow and bilateral knees pain. Examination revealed tenderness, muscle spasm, and decreased range of motion and positive Neer's, Drop Arm, Cross Chest, bilateral Spurling's, and bilateral

Straight Leg Raise (SLR) tests. The EIP then commenced on a course of physical therapy.

Ultrasound study of the right shoulder performed on July 25, 2024 revealed abnormal acromioclavicular joint and also abnormal echogenicity of the muscles and tendons bilaterally which may be due to muscle spasms, inflammation, or trauma.

MRI study of right shoulder revealed complete tear of supraspinatus tendon with retraction of torn fibers, the torn fibers seen to be retracted almost up to the glenoid, near complete tear of the subscapularis tendon with retraction of the torn fibers, partial tear of the infraspinatus tendon, hyperintense signal involving the antero-superior, superior and posterosuperior labrum raising suspicion for tear, thickening and hyper intense signal seen involving the inferior gleno-humeral ligament, suggestive of edema or adhesive capsulitis, fluid seen in subacromial - subdeltoid, subcoracoid and subscapularis bursae and also along the biceps tendon, tendinosis of the biceps tendon, medial subluxation of the biceps tendon from the bicipital groove, changes of osteoarthritis in the gleno-humeral joint, synovial effusion, moderate degenerative changes in the acromioclavicular joint, with hypertrophic spurs and with sub acromial spur.

On September 19, 2024, the EIP consulted Applicant complaining of sharp right shoulder pain with weakness. Examination of the right shoulder revealed decreased range of motion in all the planes with pain, tenderness at AC joint, misalignment at right shoulder, positive Hawkins test and positive Neer Impingement test. Neurological examination revealed decreased muscle strength at right shoulder. On October 22, 2024 EIP underwent a

right shoulder arthroscopic debridement, arthroscopic major synovectomy, arthroscopic lysis of adhesions and arthroscopic biceps tenotomy for which Applicant seeks reimbursement.

Prima Facie

The Applicant has established its prima facie case by proof that the prescribed statutory billing forms had been received and that payment of no-fault benefits was not forthcoming. (See, New York & Presbyt. Hosp. v. Countrywide Ins. Co., 44 A.D.3d 729 [N.Y. App. Div. 2d Dep't 2007]). Proof of the receipt of the Applicant's billing is implicit in the timely denial issued by the Respondent. The Respondent's obligation is to now demonstrate the validity of its denial.

Denial

The Respondent's denial raised the asserted absence of medical necessity based on the analysis of its designated peer, Dr. Douglas Unis M.D. The corresponding report dated; November 14, 2024 has been submitted in support of the Respondent's position.

In considering the issue being presented, I note that as part of its prima facie showing, the Applicant is not required to show that the contents of the statutory no-fault forms themselves are accurate or that the medical services documented, therein, were actually rendered or necessary. Stated another way, the Applicant is not required to establish the merits of the claim to meet its prima facie burden. (Viviane Etienne Med. Care, P.C. v. Country-Wide Ins. Co., 114 A.D.3d 33, 46, aff'd 25 NY3d 498)

On the contrary, "[m]edical necessity is presumed upon the timely submission of a no-fault claim (see All County Open MRI & Diag. Radiology P.C. v. Travelers Ins. Co., 11 Misc. 3d 131[A], 815 N.Y.S.2d 493, 2006 NY Slip Op 50318[U] [App Term, 9th & 10th Jud Dists 2006]).

Thus, ordinarily, it falls to the defense to establish that the billed-for services were not medically necessary." (Park Slope Med. & Surgical Supply, Inc. v. Progressive Ins. Co., 34 Misc. 3d 154[A] [N.Y. App. Term 2012] [concurring opinion, Golia, J.]; see, also, Kings Med. Supply Inc. v. Country-Wide Ins. Co., 5 Misc. 3d 767, 771 [N.Y. Civ. Ct. 2004 ["It is by now firmly established that the burden is on the insurer to prove that the medical services or supplies in question were medically unnecessary {citation omitted}."])

The Respondent, to establish the validity of its denial, on a prima facie level and put the Applicant to its proof, must, as a minimum, demonstrate, both, a factual predicate and medical rationale for the asserted absence of medical justification for the specific service provided to the EIP, and must premise its contention upon uncontroverted evidence of generally accepted medical standards of care. (See, Nir v. Allstate Ins. Co., 7 Misc. 3d 544, 547 [N.Y. Civ. Ct. 2005])

Thus, the focus falls squarely on the Unis report.

Peer

Dr. Unis contends that the subject surgery was not medically necessary because *The EIP did have a positive finding of complete tear of supraspinatus tendon, near complete tear of the subscapularis tendon, and partial tear of the infraspinatus tendon on the MRI. However, there was no notation of mechanical symptoms. Mechanical symptoms would be the main indication to proceed with surgery without attempting further conservative management…For the reasons elucidated above including the failure to undergo an appropriate preoperative conservative regimen including but not limited to structured physical therapy, in addition to there being no*

clear indications of mechanical instability on MRI, it is my opinion that the right shoulder scope surgery by Robert Drazic, DO on 10/22/2024 does not comport with the orthopedic standard of care.

Analysis

Whereas here, a peer review provides a factual basis and medical rationale for the opinions stated, the burden shifts to the provider to refute the carrier's showing with sufficient contrary proof which, if, it is to prevail, tends to establish the medical necessity for the service provided. (See, Pan Chiropractic, P.C. v. Mercury Ins. Co., 24 Misc. 3d 136[A] [N.Y. App. Term 2009]; A.M. Med. Servs., P.C. v. Deerbrook Ins. Co., 18 Misc. 3d 1139[A] [N.Y. Civ. Ct. 2008])

Moreover, the opposing showing must meaningfully refer to, or rebut, the conclusions articulated by the peer (see, Pan Chiropractic, P.C. v. Mercury Ins. Co., supra), and, in the absence of persuasive medical evidence which tends to rebut the insurer's prima facie showing of a lack of medical necessity, the carrier's position must be sustained. (See, Hong Tao Acupuncture, P.C. v. Praetorian Ins. Co., 35 Misc. 3d 131[A] [App Term 2nd Dept. April 10, 2012])

Rebuttal

In response to the peer review, the Applicant submit a rebuttal by Dr. Robert Drazic, D.O. which details "I would note that Dr. Unis in his peer report had himself acknowledged that the EIP had positive Hawkins test and positive Neer Impingement test. Also, the results of MRI revealed complete tear of supraspinatus tendon with retraction of torn fibers, the torn fibers seen to be retracted almost up to the glenoid, near complete tear of the subscapularis tendon with retraction of the torn fibers, partial tear of the infraspinatus tendon, hyperintense signal involving the antero-superior,

superior and postero-superior labrum raising suspicion for tear, thickening and hyper intense signal seen involving the inferior gleno-humeral ligament, suggestive of edema or adhesive capsulitis, fluid seen in subacromial - subdeltoid, subcoracoid and subscapularis bursae and also along the biceps tendon, tendinosis of the biceps tendon, medial subluxation of the biceps tendon from the bicipital groove, changes of osteoarthritis in the gleno-humeral joint, synovial effusion, moderate degenerative changes in the acromioclavicular joint, with hypertrophic spurs and with sub acromial spur. Additionally, the existence of the right shoulder injuries can be determined on the basis of intra-operative findings noted above which would certainly not resolve by cortisone injections and therefore surgical intervention was needed for EIP… adhesive capsulitis, fluid seen in subacromial - subdeltoid, subcoracoid and subscapularis bursae and also along the biceps tendon, tendinosis of the biceps tendon, medial subluxation of the biceps tendon from the bicipital groove, changes of osteoarthritis in the gleno-humeral joint, synovial effusion, moderate degenerative changes in the acromioclavicular joint, with hypertrophic spurs and with sub acromial spur. Additionally, the existence of the right shoulder injuries can be determined on the basis of intra-operative findings noted above which would certainly not resolve by cortisone injections and therefore surgical intervention was needed for EIP.

Analysis

Upon consideration of the arguments of counsel and after a thorough review of all submissions I find that Applicant has submitted sufficient evidence to meet its burden of demonstrating that the right shoulder arthroscopic debridement, arthroscopic major synovectomy, arthroscopic lysis of adhesions and arthroscopic biceps tenotomy were medically necessary. Respondent sets forth a factual basis and a medical rationale for denying the claim, but the Applicant's rebuttal and medical records indicate a different

conclusion, stressing the positive MRI findings and orthopedic test results After carefully weighing the evidence submitted by the parties, I find that Applicant has submitted sufficient evidence to satisfy its burden of refuting the findings of the peer review and demonstrating the medical necessity of the disputed surgery.

Accordingly, Applicant's claim is awarded.

Fee Schedule

Insurance Law § 5102(a)(1) defines "basic economic loss" as including "all necessary expenses incurred for…professional health services" subject to the limitations of Insurance Law § 5108. Insurance Law § 5108 limits the amounts to be charged by providers of health services, and states that charges for services specified in Insurance Law § 5102(a)(1) "shall not exceed the charges permissible under the schedules prepared and established by the chairman for the workers' compensation board…except where the insurer…determines that unusual procedures or unique circumstances justify the excess charge." 11 NYCRR § 65-3.16(a) provides that "[p]ayment for medical expenses shall be in accordance with fee schedules promulgated under section 5108 of the Insurance Law and contained in Part 68 of this Title (Regulation 83)." 11 NYCRR § 68.1 provides that the "existing fee schedules prepared and established by the chairman of the Workers' Compensation Board…are hereby adopted by the Superintendent of Insurance with appropriate modifications so as to adapt such schedules for use pursuant to section 5108 of the Insurance Law."

11 NYCRR 65-4.5 (o) (1) (Regulation 68-D), reads as follows: The arbitrator shall be the judge of the relevance and materiality of the evidence offered and strict conformity to legal rules of evidence shall not be

necessary. The arbitrator may question any witness or party and independently raise any issue that the arbitrator deems to making an award that is consistent with the Insurance Law and Department regulations

The Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240 (Civil Ct. Kings Co. 2006). If the Respondent fails to demonstrate by competent evidentiary proof that an

Applicant's claims were billed in excess of the appropriate fee schedules, the defense of noncompliance with the fee schedule cannot be sustained. See,Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A (App. Term 1st Dept. per curiam, 2006).

Respondent Coder

Respondent submitted a fee assessment by Gina Ball, CPC, R.N., wherein she indicated that she reviewed the documents submitted by Applicant regarding the shoulder surgery allegedly rendered to EIP. She opines that "Pursuant to the Fee Schedule, Surgery, Ground Rule 5, when multiple procedures unrelated to the major procedure adding significant time or complexity are provided, payment is for the procedure with the highest allowance plus half of the lesser procedures. Note that codes designated as add-on are exempt from this reduction… The same rule applies for bilateral procedures when such are not specifically identified in the schedule. Note that codes designated as add-on or modifier 51 exempt are not subject to this reduction… Provider also billed CPT code 23405 defined as "Tenotomy, shoulder area; single tendon." Per AMA CPT coding guidelines billed open procedure code 23405 not supported by provider operative report. Documentation supports Arthroscopic Biceps Tenotomy. Such service reflected by billed code 29822 for extensive arthroscopic

debridement. Services have not been correctly reported. Per NYS fee schedule, payment is for the procedure coded and described, irrespective of the methods and appliances used to perform the procedure. Per AMA CPT coding guidelines, open procedure was not performed, billed code not applicable. Documentation supports arthroscopic debridement/tenotomy. Such service denied as included in billed arthroscopic debridement code. Use of modifier 59 is not validated

In Summary:

29823-RT $2,065.91 As billed

29825-RT-59 $1,030.44 50% Reduction

23405-RT-59 $ 0.00 Not Supported by operative report

29821RT-59 $ 978.79 50% Reduction

Total Surgeon $4,075.14

per Surgery Ground Rule #12F, Physician Assistants will receive 10.7 percent of the total allowance for the surgical procedures.

29823-RT-83 $221.05 As billed

29825-RT-59-83 $11026 50% Reduction

23405-RT-59-83 $ 0.00 Not Supported by operative report

29821RT-59 $ 104.73 50% Reduction

Total Physician Assistant $436.04

Grand Total $4,511.18

Analysis

As to 29823, 29825 and 29821, the Applicant has not come forward with a different interpretation or calculation as to Ms. Ball's amounts, The Appellate Term, Second Department stated, "*after defendant made a prima facie showing that the amounts charged by plaintiffs for claims underlying the first and seventh causes of action were in excess of the fee schedules, the burden shifted to plaintiffs to show that the charges involved a different interpretation of such schedules or an inadvertent miscalculation or error*.", Cornell Medical PC v. Mercury Cas. Co, 2009 NY Slip OP 29228 [24 Misc 3d 58].

But as to CPT 23405, Respondent did not submit evidence, from a medical expert, explaining why CPT 23405, defined as "Tenotomy, shoulder area; single tendon" was not supported by the operative report.

CPT Code 23405 has an RVU of 5.24. and the reimbursement is calculated as follows:

5.24 x $251.94 (surgery conversion factor) x 50% = $660.08 as the surgeon's fee, for a revised surgeon's fee reimbursement of $4,735.22.

Applied the 10.7% physician assistant reduction: $660.08 x 10.7% = $70.63 for a revised physician assistant $506.67.

Applicant awarded $5,241.89.

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**
	Tri-Borough NY Medical Practice PC	**10/22/24 - 10/22/24**	**$7,404.52**	**Awarded: $5,241.89**
Total			**$7,404.52**	**Awarded: $5,241.89**

B. The insurer shall also compute and pay the applicant interest set forth below. 01/16/2025 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   Based on the submission of a timely denial, interest shall be paid from the above date, until the date that payment is made at a rate of 2% per month**.**

C. Attorney's Fees

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

   As 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 fee, in accordance with newly promulgated 11 NYCRR 65-4(d).

After calculating the sum total of the first party benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20% of the sum total, subject to no minimum and a maximum of $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, Hersh Jakubowitz, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

08/07/2025
(Dated)

Hersh Jakubowitz

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:
cfb94c31acd7340b63819830905685ff

Electronically Signed

Your name: Hersh Jakubowitz
Signed on: 08/07/2025