Allstate Ins. Co. v Health E. Ambulatory Surgical Cent.
2017 NY Slip Op 30663(U)
February 20, 2017
Supreme Court, New York County
Docket Number: 652106/2016
Judge: David B. Cohen

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 58

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ALLSTATE INSURANCE COMPANY

Plaintiff,

-against-

HEALTH EAST AMBULATORY SURGICAL CENTER A/A/O BUJAR KAZIU,

Defendant.

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DECISION/ORDER
Index No. 652106/2016

HON. DAVID B. COHEN, J.:

This matter, brought pursuant to NY Insurance Law 5106(c), seeks *de novo* adjudication of the dispute between the parties concerning no-fault benefits. Although the parties submitted to mandatory arbitration, since to arbitrator awarded defendant a sum greater than $5,000, plaintiff is permitted to bring this action. Both plaintiff and defendant have moved for summary judgment.

On January 31, 2014, Bujar Kaziu the assignor, was in an automobile accident and began to receive no-fault benefits. On June 6, 2014, plaintiff's claim representative determined that additional verification in the form of an independent medical examination ("IME") was required and properly noticed an IME for June 26, 2014. The assignor failed to appear for the IME on June 26, 2014 and verification was again sought on July 1, 2014 by scheduling an IME on July 17, 2014. On July 1, 2014, the assignor had a surgery on his right shoulder. Defendant provider Health East Ambulatory Surgical Center timely submitted a claim on July 3, 2014 seeking $30,365.16 in reimbursement.

On July 10, 2014, plaintiff rescheduled the July 17, 2014 IME to August 21, 2014. Plaintiff did not provide this Court with any reason why the IME was scheduled, nor did plaintiff state that the rescheduling was done at the request or with the consent of the assignor. The July 10, 2014 letter states that the reason for the rescheduling was due to the July 1, 2014 surgery. Plaintiff alleges that it received the bill for the surgery on July 11, 2014. On August 21, 2014, Dr. Dorothy Scarpinato performed the IME and issued her report. Dr. Scarpinato found that right shoulder surgery was not medically necessary or causally related.

On September 18, 2014, plaintiff denied the July 1, 2014 claim based on a lack of medical necessity and because the amount sought was in excess of the appropriate fee schedule.

As the parties disputed the validity of the denied claims, they went to arbitration. Arbitrator Paul Israelson found that the September 18, 2014 denial was not timely and accordingly found in favor of defendant on liability. However, the arbitrator also found that defendant did not submit the claim pursuant to the proper New Jersey fee schedule and reduced the amount to $18,154.85. Plaintiff commenced this action seeking *de novo* adjudication of the dispute. At present, defendant acknowledges that the fee calculation was not correct and seeks an amended amount of $21,903.93 for the surgery performed on July 1, 2014.

It is well established that an insurer must pay or deny a claim within 30 days (11 NYCRR 65-3.8(1), "No-fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested pursuant to section 65-3.5 of this Subpart."). A defense predicated on a lack of medical necessity must be asserted within that time period (*Careplus Med. Supply, Inc. v Selective Ins. Co. of Am.*, 25 Misc 3d 48 [App Term 2d Dept 2009] *citing Fair Price Med. Supply Corp. v. Travelers Indem. Co.,* 10 NY3d 556 [2008]; *Presbyterian Hosp. in City of N.Y. v. Maryland Cas. Co.,* 90 NY2d 274 [1997]; and *Melbourne Med. P.C. v. Utica Mut. Ins. Co.,* 4 Misc3d 92 [App. Term, 2d & 11th Jud. Dists. 2004]). Here, plaintiff alleges that it received the claim on July 11, 2014. Thus, plaintiff must have paid or denied the claim by August 11, 2014, unless plaintiff properly sought verifications.

Plaintiff alleges that it received the claim for the July 1, 2014 bill on July 11, 2014. Thus, any requests for an IME, including the request on June 6, 2014, the follow-up on July 1, and the rescheduling on July 10, 2014, are pre-claim requests. Following the July 11, 2014 receipt of the bill, the first communication by plaintiff was the July 31, 2014 delay letter. The insurance regulations permit pre-claim IMEs, but without consequence for the running of the 30–day claim determination period (*Stephen Fogel Psychological, P.C. v. Progressive Cas. Ins. Co.,* 7 Misc3d 18 [App Term, 2d & 11th Jud. Dists 2004]). Any post-claim IME verification requests must be made within required time constraints set forth in 11

NYCRR 65–3.5 [a], [d]; 11 NYCRR 65–3.6[b], including the initial request within 10 days of the claim's filing (to be scheduled within 30 days of the claim's receipt) and a "follow-up" request within 10 days of a subject's non-appearance at the initially-scheduled IME (*A.B. Med. Services PLLC v Utica Mut. Ins. Co.*, 10 Misc 3d 50 [2d Dept App Term 2005]).

Here, even assuming that plaintiff's July 31 delay letter meets the criteria for an initial verification request[1], plaintiff's delay letter sent on July 31, 2014 was later than the period allowed to seek verification under the statute. However, said tardiness is not fatal. "An insurer that requests additional verification after the 10– or 15–business–day periods but before the 30–day claim denial window has expired is entitled to verification. In these instances, the 30–day time frame to pay or deny the claim is correspondingly reduced" (*Hosp. for Joint Diseases v Travelers Prop. Cas. Ins. Co.*, 9 NY3d 312, 318 [2007]). 10 Business days from July 11, 2014 was July 25, 2014. As the delay letter was sent out on July 31, 2014, the 30-day time frame must be reduced by 5 days, leaving plaintiff with 25 days.

In the case of an examination under oath or a medical examination, the verification is deemed to have been received by the insurer on the day the examination was performed (11 NYCRR 65-3.8(1)). The IME was performed on August 21, 2014 and the denial was sent on September 18, 2014, 28 days later. As the time frame to pay or deny was reduced from 30 to 25 days and the denial was sent 28 days later, the denial was untimely.

Further, on July 10, 2014 plaintiff rescheduled the IME from July 17, 2014 to August 21, 2014. Even assuming that this IME scheduling was for the purposes of verifying the July 11, 2014 claim (despite the assertion that the receipt of the claim was July 11, 2014, the reschedule letter states that it was done because the assignor had surgery) plaintiff does not provide any affidavit explaining the basis of scheduling the IME so far in the future. Generally speaking, the insurance regulations require that an IME be

[1] The Court makes no ruling that the delay later was a valid initial verification request (*see Nyack Hosp. v Encompass Ins. Co.*, 23 AD3d 535 [2d Dept 2005][*holding* that a delay later which did not seek verification in it did not toll the 30-day period to pay or deny]).

scheduled within a 30–calendar–day time frame from receipt of the claim (*Am. Tr. Ins. Co. v Longevity Med. Supply, Inc.*, 131 AD3d 841 [1st Dept 2015] *citing W.H.O. Acupuncture, P.C. v. Travelers Home & Mar. Ins. Co.*, 36 Misc.3d 152[A] [App Term 2d Dept 2012]; *American Tr. Ins. Co. v. Jorge*, 2014 N.Y. Slip Op. 30720[U], 2014 WL 1262582 [Sup Ct NY County 2014]; (11 NYCRR § 65–3.5(d)). Although, by consent, the parties can agree to a later time frame, here the record is completely devoid of any communication, let alone consent, or any other reason why the IME was scheduled past the 30-day frame permitted by statute. As the IME was re-scheduled past the 30-day time frame, the IME was not properly scheduled or sought and the denial was late and invalid.

However, even though the denial based upon on causal connection and medical necessity was not timely, services here were rendered after April 1, 2013, and the defense of excessive fees is not subject to preclusion (*see* 11 NYCRR 65–3.8 [g]; *Surgicare Surgical Assoc. v Natl. Interstate Ins. Co.*, 50 Misc 3d 85 [App Term 1st Dept 2015]). Although defendant initially sought $30,365.16, defendant acknowledges that appropriate amount per the New Jersey Fee Schedule is really $21,903.93. Plaintiff disagrees and states that appropriate amount would be $18,413.80, slightly more than the amount found by the arbitrator. Thus, because the denial with respect to non-fee schedule defenses was not timely and plaintiff has made no payments, defendant is entitled to at least the portion of the claim that is undisputedly pursuant to the fee schedule $18,413.80.

The difference between the two amounts is whether the portion of the claim pursuant to CPT Code 29826 and 64415 are reimbursed at 100% or 50%. Specifically, the provider billed $6,462.39 under CPT 29826. Plaintiff reduced the amount by 50% to $3,231.20 pursuant to NJ 11:3-29.5(d). Similarly, the provider billed $517.89 under CPT 64415 and plaintiff reduced the amount by 50% to $258.95 pursuant to NJ 11:3-29.5(d). Both sides have submitted the affidavits of their fee schedule/coding experts. The Court finds that pursuant to NJ Admin Code 11:3-29.4(f)(2)[2], add-on codes are exempt from the multiple

[2] NJ Admin Code 11:3-29.4(f)(2) states "There are two types of procedures that are exempt from the multiple procedure reduction…In addition, some related procedures are commonly carried out in addition to the primary procedure. These procedure codes contain a specific descriptor that includes the words, "each additional" or "list separately in addition to the primary procedure." These add-on codes cannot be reported

procedure reduction. Therefore, CPT 29286 should be reimbursed at 100%, or $6,462.39. Similarly, the claim included a modifier for CPT 64415 and defendant should be reimbursed at 100% or $517.89. Accordingly, defendant is entitled to a total amount of $21.903.93.

It is therefore

ORDERED, that plaintiff's motion for summary judgment is denied; and it is further

ORDERED, that defendant's cross-motion for summary judgment is granted.

DATE : 2/9/2017

COHEN, DAVID B., JSC

as stand-alone codes but when reported with the primary procedure are not subject to the 50 percent multiple procedure reduction." CPT 29826 is listed as an "add-on" code.