American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Life Health Care Medical (Applicant)	AAA Case No. Applicant's File No.	17-16-1030-7059 59387
- and -		
Geico Insurance Company (Respondent)	Insurer's Claim File No. NAIC No.	0527495010101018 22055

ARBITRATION AWARD

I, Aaron Maslow, 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: Assignor ["DN"]

1. Hearing(s) held on 02/27/2017
   Declared closed by the arbitrator on 02/27/2017

   Jeff Henle, Esq., from Gitelis Law Firm, PC participated in person for the Applicant

   Dustin Mule from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 844.47**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bills. They also stipulated that Respondent's Form NF-10 denial of claim forms were timely issued, i.e., within the 30-day deadline prescribed by Insurance Law §5106(a) and 11 NYCRR 65-3.8(a)(1). Additionally, they stipulated that should Applicant prevail, interest would accrue as of the filing date set forth by the American Arbitration Association in Part B of the conclusion of the award template.

3. Summary of Issues in Dispute

- Whether Applicant established entitlement to No-Fault insurance compensation for outcome assessment testing, physical performance testing, and office visits performed to treat Assignor

- Whether to award for compensation for outcome assessment testing denied on the basis that more than one visit/consultation on the same date of service is not reimbursable

- Whether Respondent made out a prima facie case of lack of medical necessity for further medical services past its IEM cutoff and, if so, whether Applicant rebutted it

4. Findings, Conclusions, and Basis Therefor

Appearances

For Applicant:

Gitelis Law Firm, P.C.
2004 Coney Island Avenue
Brooklyn, NY 11223
Of counsel: Jeff Henle, Esq.

For Respondent:

Dustin Mule
Claims Representative
GEICO
750 Woodbury Road
Woodbury, NY 11797

Applicant commenced this New York No-Fault insurance arbitration, seeking as compensation $844.47 which it billed for performing outcome assessment testing, physical performance testing, and office visits during the period of Aug. 12, 2015 to Dec. 14, 2015, to treat Assignor, a 28-year-old male who was injured in a motor vehicle accident on June 9, 2015. Five bills are involved. None were paid by Respondent. Respondent denied payment for bills for Oct. 22, 2015 (physical performance testing); Nov. 11, 2015 (follow-up office visit); Nov. 11, 2015 (outcome assessment testing); and Dec. 14, 2015 (follow-up office visit) on the basis of an IEM cutoff having been imposed effective Sept. 29, 2015. A bill for outcome assessment testing on Aug. 12, 2015 was denied on the basis that "More than one visit/consultation by the same provider on the same Date of Service is not reimbursable."

This arbitration was conducted under the auspices of the American Arbitration Association, which has been designated by the New York State Department of Financial Services to administer the mandatory arbitration provisions of Insurance Law § 5106(b), which provides:

> Every insurer shall provide a claimant with the option of submitting any dispute involving the insurer's liability to pay first party ["No-Fault insurance"] benefits, or additional first party benefits, the amount thereof or any other matter which may arise pursuant to subsection (a) of this section to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent.

Both parties appeared at the hearing (Applicant by counsel and Respondent by an employee), presented oral argument, and relied upon documentary submissions. I have reviewed the submissions' documents contained in the American Arbitration Association's ADR Center as of the date of the hearing, said submissions constituting the record in this case.

The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bills. They also stipulated that Respondent's Form NF-10 denial of claim forms were timely issued, i.e., within the 30-day deadline prescribed by Insurance Law §5106(a) and 11 NYCRR 65-3.8(a)(1).

As noted above, Applicant's bill ($204.14) for date of service Aug. 12, 2015 was denied on the ground that "More than one visit/consultation by the same provider on the same Date of Service is not reimbursable." While not perfectly conveyed in the wording used, the denial indicates that Applicant was not entitled to both an office visit and the billed outcome assessment testing. I agree.

The Workers' Compensation Medical Fee Schedule, which governs No-Fault insurance by operation of Insurance Law §5108(a), defines Code 99358 as "Prolonged evaluation and management service before and/or after direct (face-to-face) patient care; first hour."

In Ground Rule 8 to the Evaluation and Management chapter of the Workers' Compensation Medical Fee Schedule, concerning Code 99358, it states, "These prolonged physician services without direct patient contact may include review of extensive records and tests, and communication (other than telephone calls, 99441-99443) with other professionals and/or the patient and family. These are beyond the usual services and include both inpatient and outpatient settings. Report these services in addition to other services provided, including any level of E/M service." The ground rules in the Workers' Compensation fee schedules do apply to No-Fault. 11 NYCRR 68.1(b)(1).

Respondent's submission contains computer-generated summaries of responses to fill-in questionnaire tests which were administered to Assignor. There is no indication that the results were reviewed with anyone, let alone the patient.

The purpose for Code 99358 is obviously to enable a doctor to be compensated for the extensive review of medical records and prior test results so that there can be an intelligent discussion with others about them. Its purpose is not to provide extra compensation for doctors who examine a patient and then review computer-generated results of questionnaires completed by the patient on the day of an office visit. The office visit includes taking a history and these test questionnaires should be deemed a component of history taking.

Respondent was correct in asserting in its denial that both an office visit and the billed outcome assessment testing were reimbursable. The Ground Rules are a component of the fee schedule. The documentation submitted evidenced that Ground Rule 8 of the Evaluation and Management chapter of the Medical Fee Schedule was not complied with. I sustain Respondent's defense. This defense overcomes the prima facie case of entitlement to No-Fault compensation initially established by Applicant.

The remainder of the bills at issue were denied on the basis of an IEM cutoff which went into effect on Sept. 29, 2015. The affected bills and pertinent details are as follows:

- Oct. 22, 2015: physical performance testing, $249.96
- Nov. 11, 2015: Code 99214 office visit, $92.98
- Nov. 11, 2015: outcome assessment testing, $204.41
- Dec. 14, 2015: Code 99214 office visit, $92.98

Since Respondent's denials were timely (as stipulated by the parties), it was within its rights to assert lack of medical necessity for further treatment as a defense. Liberty Queens Medical, P.C. v. Liberty Mutual Insurance Co., 2002 WL 31108069 (App. Term 2d & 11th Dists. June 27, 2002); cf. Country-Wide Insurance Co. v. Zablozki, 257 A.D.2d 506, 684 N.Y.S.2d 229 (1st Dept. 1999).

An IME doctor must establish a factual basis and medical rationale for his asserted lack of medical necessity of further health care services. E.g., Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), 2008 WL 4222084 (App. Term 2d & 11th Dists. Sept. 3, 2008). If he does so, it becomes incumbent on the claimant to rebut the IME review, see AJS Chiropractic, P.C. v. Mercury Ins. Co., 2009 WL 323421 (App. Term 2d & 11th Dist. Feb. 9, 2002), because the ultimate burden of proof on the issue of medical necessity lies with the claimant. See Insurance Law § 5102; Wagner v. Baird, 208 A.D.2d 1087, 617 N.Y.S.2d 919 (3d Dept. 1994); Shtarkman v. Allstate Insurance Co., 2002 WL 32001277 (App. Term 9th & 10th Jud. Dists. 2002) (burden of establishing whether a medical test performed by a medical provider was medically necessary is on the latter, not the insurance company). The insured or the provider bears the burden of

persuasion on the question of medical necessity. Bedford Park Medical Practice P.C. v. American Transit Ins. Co., 8 Misc.3d 1025(A), 806 N.Y.S.2d 443 (Table), 2005 WL 1936346 (Civ. Ct. Kings Co., Jack M. Battaglia, J., Aug. 12, 2005). This burden of proof is properly placed on a claimant health care provider because presumably it is in possession of the injured party's medical records.

"Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity (see Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11th ed])." West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 824 N.Y.S.2d 759 (Table), 2006 WL 2829826 (App. Term 2d & 11th Dists. Sept. 29, 2006). Assuming the insurer establishes a lack of medical necessity based upon an IME doctor's testimony, it is ultimately the claimant who must prove, by a preponderance of the evidence, that the services were medically necessary. Amato v. State Farm Ins. Co., 40 Misc.3d 129(A), 975 N.Y.S.2d 364 (Table), 2013 N.Y. Slip Op. 51113(U), 2013 WL 3497906 (App. Term 2d, 11th & 13th Dists. July 3, 2013), rev'g, 30 Misc.3d 238, 910 N.Y.S.2d 637 (Dist. Ct. Nassau Co. 2010) (district court held that IME cannot form basis for denying benefits unless post-IME records are reviewed); see also Dayan v. Allstate Ins. Co., 49 Misc.3d 151(A), 29 N.Y.S.3d 846 (Table), 2015 N.Y. Slip Op. 51751(U), 2015 WL 7900115 (App. Term 2d, 11th & 13th Dists. Nov. 30, 2015); Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co., 37 Misc.3d 19, 22 n., 952 N.Y.S.2d 372, 374 n. (App. Term 2d, 11th & 13th Dists. 2012).

The IME report relied upon by Respondent was written by Dr. Andrew Miller, M.D., an orthopedic surgeon It is dated Sept. 2, 2015, when he examined Assignor. At the outset, Dr. Miller noted that Assignor was a restrained front-seat passenger in a vehicle on June 9, 2015, when an accident occurred. He did not go to the hospital. Initial complaints of pain were regarding the neck, mid back, lower back, and right shoulder. On June 11, 2015, Assignor began treatment at a local clinic.. He was started on a regimen of chiropractic, acupuncture, physical therapy, and massage. Assignor complained to Dr. Miller about pain in the mid back and right shoulder, as well as pain in the lower back radiating to the lower extremities.

Examination of the thoracic spine yielded no tenderness to palpation. There was no spasm. Lateral bending was to 45 degrees (45 degrees normal). Rotation was to 30 degrees (30 degrees normal).

In the lumbar spine, there was no spasm or tenderness. Range of motion was as follows: flexion 60/60 degrees, extension 25/25 degrees, and right and left lateral bending 25/25 degrees. Deep tendon reflexes in the knees and ankles were 2+. Muscle strength was 5/5. There were no sensory deficits in the lower extremities. Straight Leg Raise was negative.

In the right shoulder, there was no effusion, crepitus, or tenderness. Abduction and forward flexion were to 180 degrees, which was normal. Internal and external rotation were normal to 90 degrees. Impingement Sign was negative.

Dr. Miller listed the various medical records which he reviewed. He diagnosed status post sprain/strain in the thoracic and lumbar spines, resolved right shoulder sprain. He opined, "The claimant has no orthopedic disability." "No further orthopedic intervention is indicated, and any such treatment would be considered excessive," added Dr. Miller. This included physical therapy and diagnostic testing. As noted above, an IME doctor's report must contain a factual basis and a medical rationale. Dr. Miller's report contained both. For Respondent it established a prima facie case of lack of medical necessity for the physical therapy services at issue in this case -- post IME-cutoff of Sept. 29, 2015. The burden of proof shifted to Applicant to rebut Dr. Miller's report and affirmatively prove medical necessity.

Applicant argued that two follow-up reports dated Nov. 11, 2015 and Dec. 14, 2015 rebutted Dr. Miller's IME report. I reject this argument. These reports were not contemporaneous with the IME report.

As such I find that Applicant failed to meet its burden of proof. Respondent proved lack of medical necessity for the services which were performed subsequent to the IME cutoff. I sustain the IME-cutoff defense asserted in Respondent's denial of claim forms. That defense overcomes the prima facie case of entitlement to No-Fault compensation established at the outset by Applicant.

Accordingly, the within arbitration claim is denied in its entirety.

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 claim is DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York
SS :
County of Kings

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

03/01/2017
(Dated)

Aaron Maslow

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:
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Electronically Signed

Your name: Aaron Maslow
Signed on: 03/01/2017