American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Patchogue Open MRI (Applicant)	AAA Case No.	17-16-1030-4028
	Applicant's File No.	307114
- and -	Insurer's Claim File No.	0478045960101036
	NAIC No.	22063
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Bonnie Link, 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: the EIP

1. Hearing(s) held on 05/01/2017
   Declared closed by the arbitrator on 05/01/2017

   Alan Elis, Esq. from Rubin & Licatesi, P.C. participated in person for the Applicant

   Erica Avella, Esq. from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,790.67**, was AMENDED and permitted by the arbitrator at the oral hearing.
   The amount in dispute is reduced by the Applicant to $1,351.34, per fee schedule for two MRIs conducted on the same day.

   Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute
   This arbitration arises out of treatment of a 12 year old female for injuries sustained in a motor vehicle accident occurring on July 13, 2015. Applicant seeks reimbursement for lumbar and left hip MRIs provided on August 26, 2015 in the amount of $1, 351.34. Respondent timely denied the bills based upon Peer Reviews by Dr. Dominic Garofalo dated September 29, 2015 (lumbar) and October 8, 2015

(left hip) that found that the treatment was not medically necessary. A rebuttal by Dr. David Payne, M.D. dated February 29, 2016 and an addendum by Dr. Garofalo dated April 13, 2016 are submitted and reviewed.

Whether this arbitration may proceed in the absence of court order, as the EIP is a minor.

4. Findings, Conclusions, and Basis Therefor

:

This matter is determined after reviewing the documents contained in the electronic case folder at the closing of the file and the presentations of both sides.

This arbitration arises out of treatment of a 12 year old female for injuries sustained in a motor vehicle accident occurring on July 13, 2015. Applicant seeks reimbursement for lumbar and left hip MRIs provided on August 26, 2015 in the amount of $1,351.34. Respondent timely denied the bills based upon Peer Reviews by Dr. Dominic Garofalo dated September 29, 2015 (lumbar) and October 8, 2015 (left hip) that found that the treatment was not medically necessary. A rebuttal by Dr. David Payne, M.D. dated February 29, 2016 and an addendum by Dr. Garofalo dated April 13, 2016 are submitted and reviewed.

Minor:

I have thus far predominantly found that when the EIP is a minor, the provider/assignee does not have standing to arbitrate the claim without a court order. I do so based on CPLR 1209 and because a finding that the infant is no longer in need of care (such as when the denial is based on an IME) or that certain treatment (i.e., surgery) is not medically necessary (based on a peer review) might inure to the infant's detriment in a lawsuit against a driver.

> CPLR 1209 provides: "A controversy **involving an infant**, person judicially declared to be incompetent or conservatee shall not be submitted to arbitration except pursuant to a court order made upon application of the representative of such infant, incompetent or conservatee; provided, however that a claim brought on behalf of an infant pursuant to paragraph one or two of subdivision (f) of section three thousand four hundred twenty of the insurance law may be submitted to arbitration without a court order." (Emphasis supplied.)

When parents bring a negligence claim on behalf of an infant, they are not entitled to settle the claim without court approval, even if it is settled at the pre-litigation stage. In the no-fault arena, however, by assigning the infant's no-fault benefits to a medical provider and allowing it to arbitrate the no-fault insurer's denial of the minor's entitlement to benefits, the parents risk an arbitrator's decision that the child is not or no longer injured. In no-fault, the insurer may deny the claim based on an IME report that states that the infant is no longer (or not) injured. More obviously egregious is an insurer's denial of a provider's claim based on the infant's failure to attend an IME. This, of course, is directly due to a parent's decision based on unknown factors not to take the child. This decision can be held against the infant in his/her claim for bodily injury, thereby circumventing the intent of CPLR 1209 which is to give the courts supervisory authority over the infant's case.

CPLR 1209 was amended in 1997 to allow UM and SUM arbitrations to go forward despite the age of the patient whose parents become the assignor of the claim. There was no such exception made for no-fault arbitrations. Under the doctrine of *expression unius est exclusion alterius*, the expression of one thing is the exclusion of another. The intention to exclude other arbitrations is presumed.

As stated by Arbitrator Aaron Maslow in AAA Case # 412012003514, "the provisions of CPLR 1209 are designed to ensure that courts safeguard the rights and interests of infants, whom courts are bound to protect. Cutway v. S.T.A.R. Programs, Inc., 75 A.D.3d 811, 904 N.Y.S.2d 806 (3d Dept. 2010). A decision in arbitration could potentially have collateral estoppel effects that may be deleterious to the interests of the minor. It is to the minor's benefit to have a court adjudicate whether arbitration is in the minor's best interests.

Arbitrators have been split on whether or not the cases should be heard or dismissed without prejudice. Some are swayed by the legal fiction created by the assignment of benefits signed by the parent on behalf of the child. Once the claim is assigned to the provider, the child is no longer a party to the arbitration. Some decide that the goal of prompt payment is paramount. Reg. Sec. 65-3.2 pre-arb discovery: The primary aim of the no-fault system is to ensure prompt compensation for losses incurred by accident victims and to pay benefits as losses are incurred. Medical Society of the State of N.Y. v. Serio, 100 NY 2d 854.

I have mostly concurred with Arb. Maslow and dismissed without prejudice cases involving treatment to minors where the issue is medical necessity or causality unless CPLR §1209 is satisfied, or, in the cases where a minor turns eighteen and the provider obtains a ratification. I have recently decided to proceed with arbitration when the only issue is the quantum of the provider's fee, such as in a dispute between the use of a specific fee code, relative value or conversion factor (i.e. where the denial is not based on the infant's condition or conduct.) And, see, for example,

CAC Master Acupuncture/TP v. American Independent Ins., AAA Case #171490529077 (7/30/15) where the denial was based on the failure of the injured party, a minor, to timely submit a no-fault application, I found as follows:

> *In as much as the claim involves treatment of a minor and, more importantly, a denial*
>
> *based on the* ***failure of a minor to comply with a requirement of the insurance policy****, I*
>
> *find that the matter should be dismissed without prejudice until a court order is obtained*
>
> *allowing the matter to continue in arbitration.(Emphasis supplied.)*

Recently, Judge Rudoph E. Greco, Jr., of the Supreme Court, Queens County, vacated a Master Arbitration Award that had affirmed a lower arbitrator's dismissal without prejudice of a provider's claim for reimbursement for treatment rendered to a minor that was timely denied based on medical necessity on the ground that it was arbitrary or capricious. Judge Greco, in NY Med., as Assignee of Tanise Washington v. Geico, Index #700058/15, Sup. Ct., Queens Cnty., J.Greco (March 4, 2015), found first that the Master Award's reliance on CPLR §1209 to dismiss the arbitration without prejudice was "arbitrary and capricious" and vacated the award on that ground even though that bases to vacate the Master's award is not one of the four specific grounds listed in CPLR § 7511(b). Judge Greco then determined that case law has interpreted that CPLR §1209 only applies when the infant is a party to an action and that since the EIP had "assigned her benefits" to the Plaintiff, she was no longer a party. The Court appears to be swayed by the paucity of argument offered by the Respondent. In a footnote, the Court noted that "the validity of the assignment was not in issue and was never objected to."

The short form decision does not address whether the denial was based on a peer review or an independent medical exam and does not discuss the potential collateral estoppel of such a decision. It has been held that the doctrines of res judicata and collateral estoppel apply to arbitration awards, "including those rendered in disputes over no-fault benefits, and will bar relitigation of the same claim or issue". Furthermore, it has been held that "a judgment in one action is conclusive in a later one…when the two causes of action have such measure of identity that a different judgment in the second would destroy or impair rights or interests established by the first…" *See*: Matter of Ranni, 58 N.Y.2d 715, 458 N.Y.S.2d 910 (1982); Monroe v. Providence Washington Ins. Co., 126 A.D.2d 929, 511, N.Y.S.2d 449 (3d Dept. 1987).

Judge Greco does not address the fact that it is the parent, **not the child**, who is the assignor, or that the parent does not even have the unfettered discretion to settle their child's bodily injury claim without an order from the court allowing the settlement. CPLR Art. 12.

The decisions by the trial court is not settled law and is not binding in this forum. State Farm Mut. Auto. Ins. Co. v. Lumbermens Mut. Cas Co., 18 AD3d 762 (2005). I **have** dismissed without prejudice those matters which have been denied based on the IME or the failure of the infant to appear at an IME **and will continue to do so**.

In this instance, I am swayed that the insurer's denial of the claim for MRIs based on a peer review would not require a finding that the infant has/has not recovered or was/was not in need of care, but more, that this particular test might not have been warranted at the particular time it was prescribed. My opinion would not be based on the results of the test or the injury to the EIP, but on the evidence presented that the test itself was/was not medically necessary. This decision should not have any real effect on the infant's personal injury claim and would allow a provider's claim to go forward in an expeditious fashion, a desired aim of the no-fault regulations.

Accordingly, I will proceed to the merits of the claim and the peer review.

Peer Reviews:

The patient was a pedestrian when she was struck by motor vehicle. She was transported by ambulance to a local emergency room. She had x-rays of the left elbow and forearm and CT scans of the abdomen and pelvis, cervical spine, chest, head, left knee and left tibia/fibula. She came under the care of private medical providers and was commenced on a regimen of chiropractic and acupuncture. She had an orthopedic examination on July 16, 2015 and a follow-up orthopedic examination on August 7, 2015. She had the subject lumbar and left hip MRIs on August 26, 2015, prescribed by Dr. Walter Mendoza, D. C.

The peer reviews by Dr. Garofalo were based on a review of the EIP's medical records including the emergency room record, including the x-rays and CAT scans, the chiropractic and acupuncture evaluations and progress notes in the orthopedic evaluations. He based his conclusion on his opinion that the chiropractic evaluations did not contain a complete (sufficient) neurological assessment of the lower extremities, persistent focal neurological deficits after six weeks of conservative therapy were not noted and the results of the testing would not aid in the patient's chiropractic care and treatment. Specifically with regard to the hip MRI, Dr. Garofalo states that the lower extremity joints are outside the purview of chiropractic expertise and that it would be usual and customary to refer to these patients to an

orthopedist. (As discussed later, in this case, the infant did see an orthopedist for the let hip complaints and the orthopedist did not order this testings.)

It is well settled that an applicant establishes its prima facie entitlement to payment by proving it submitted a claim setting forth the facts and the amount of the loss sustained and that payment of no fault benefits were overdue (see Insurance Law § 5106[a]; Mary Immaculate Hospital v Allstate Ins. Co. 5 A.D.3d. 742 Second Dep't 2004), A.B. Medical Services PLLC v Lumbermans Mutual Cas. Co., 4 Misc. 3d. 86 (App. Term 2d. & 11th Jud. Dists. 2004).

When evaluating the medical necessity of services, particularly when the conclusion is contradictory, consideration must be given to the evidentiary burdens. Respondent must prove first that the services were not medically necessary. The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment Kingsborough Jewish Med. Ctr. v. All State Ins. Co., 61 A.D. 3d. 13 (2d. Dep't, 2009). An insurance carrier must at a minimum establish a detailed factual basis and a sufficient medical rationale for asserting lack of medical necessity. See Delta Diagnostic Radiology PC v. Progressive Casualty Ins. Co., 21 Misc. 3d. (142A) (App. Term 2d. Dep't, 2008).

A peer review report relied upon by an insurer in timely denying a claim is a proper vehicle to assert the defense of lack of medical necessity. S & M Supply, Inc. v. Allstate Ins. Co., 2003 N.Y. Slip Op. 51191(U), 2003 WL 21960336 (App. Term 2d & 11th Dists. July 9, 2003); Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp., 2003 N.Y. Slip Op. 50842(U), 2003 WL 21049583 (App. Term 2d & 11th Dists. Apr. 1, 2003).

In order to support a viable denial on grounds of medical necessity, the peer review report must "set forth a sufficiently detailed factual basis and medical rationale for the claim's rejection." Amaze Medical Supply v. Eagle Ins. Co., 2 Misc.3d 128(A), 2003 N.Y. Slip Op. 51701[U], 2003 WL 23310886 (App. Term, 2d and 11th Jud. Dists. 2003); S & M Supply Inc. v. Kemper Auto & Home Ins. *Co.*, 2 Misc.3d 134(A), 2004 N.Y. Slip Op. 50209[U], 2004 WL 758247 (App. Term, 2d and 11th Jud. Dists. 2004). A "peer review report must set forth a factual basis sufficient to establish, prima facie, the absence of medical necessity." Choicenet Chiropractic P.C. v. Allstate Ins. *Co.*, 2003 N.Y. Slip Op. 50672[U], 2003 WL 1904296 (App. Term, 2d and 11th Jud. Dists. 2003) (emphasis supplied).

For a peer review to meet its burden, it must demonstrate that the Applicant did not need to conduct or treat a patient to prevent an injury, make a diagnosis or formulate a treatment plan. If the results of testing do not change the conclusion drawn from a physical examination it is excessive, or not medically necessary. A.M. Med. Servs., P.C. v. Deerbrook Ins. Co., 2008NY Slip Op 50368(U)(Civil Ct., Kings Co.).

"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 N.Y. Slip Op. 51871(U) at 2, 2006 WL 2829826 (App. Term 2d & 11th Dists. Sept. 29, 2006).

Dr. Garofalo's peer reviews are adequate to meet the Respondent's burden of proof. They contain a sufficiently detailed and credible record review and sufficiently analyze the information maintained in the EIP's medical records. They are based on Dr. Garofalo's educated opinion of the testing conducted and explain when such testing is medically necessary. They are clear about the standard of care and cite to the medical authority upon which they are based. They amply reference the patient, her history, complaints offered and clinical findings and contains a sufficient "factual basis and medical rationale" to support a medical necessity defense under apposite legal standards, as set forth above.

Further, I find that the doctor's analysis, which relies, in part, on an insufficient clinical examination and the absence of proof that the testing was material to any treatment plan, is persuasive.

This is not a situation where the reviewer denies medical necessity because additional information was necessary to draw a conclusion, Nir v. Allstate Ins. Co., 7 Misc.2d 544, 547, 796 N.Y.S.2d 857, 860 (Civ. Ct. Kings County. 2005), but rather a situation where the records of the EIP's doctor do not support his own treatment or testing.

Based on the foregoing, I find that the Respondent has met its burden of proving the lack of medical necessity. The burden sufficiently shifts to the Applicant. Dr. Payne, of the Applicant, Southwest Radiology, states that Dr. Mendoza's examination on August 3, 2015 revealed positive findings including, but not limited to pain in the left hip and lumbar spine and that these objective orthopedic tests indicated the possibility of a disc involvement or hip pathology. He notes that Dr. Garofalo's record review is flawed because while he states that the appropriate action would have been to refer the patient to an orthopedist, he fails to note that she was seen by an orthopedist 22 days before she initially saw Dr. Mendoza. He notes that the orthopedist also saw the patient on August 3, 2015. Dr. Payne also states that Dr. Garofalo's argument that the MRI should not be conducted until 4 to 6 weeks from the start of conservative treatment, these were in fact conducted 41 days after the

start of such treatment, well within the 4 to 6 week period cited. He adds that experts disagree on the timeframe and that other medical authorities suggest that the best times for such imaging are a 2 to 3 weeks.

Dr. Garofalo's addendum questions why the peer review rebuttal should be written by the radiologist and not the provider who referred the patient for the studies but also points out that the rebuttal ignores the argument that the MRIs were ordered in the absence of a complete neurological assessment of the lower extremities. Further, Dr. Garofalo stated that the EIP was initially evaluated by her orthopedist, Dr. Meredith A. Lazar-Andria, M.D., on July 16, 2015 and that at that time there was only a complaint of left hip pain and no complaint of low back pain. The records do not indicate any complaint of low back pain until chiropractic treatment actually started with Dr. Mendoza on August 3, 2015, which, he points out is later then stated by Dr. Payne.

I also note that the orthopedist made no recommendations for any MRIs either on July 16, 2015 or at the follow-up evaluation on August 3, 2015. She noted that the EIP went on a family vacation two days after the initial evaluation and was improving when she saw her during the follow-up. She was referred for physical therapy.

Dear Payne's rebuttal is deficient. I am swayed by Dr. Garofalo's reviews and the evidence presented and in the absence of a sufficient rebuttal thereto or convincing medical evidence, the peer review is sustained as being supported by a preponderance of the credible evidence. The Applicant herein has failed to overcome Respondent's evidence.

Accordingly, the Applicant's claim is denied.

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 Nassau

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

05/16/2017
(Dated)

Bonnie Link

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: Bonnie Link
Signed on: 05/16/2017