

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Westchester Radiology & Imaging, PC
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No. 17-16-1029-8184

Applicant's File No.

Insurer's Claim File No. 0262408400101059

NAIC No. 35882

ARBITRATION AWARD

I, Eylan Schulman, 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 06/01/2017
Declared closed by the arbitrator on 06/01/2017

Matt Viverito, Esq., from Costella & Gordon LLP participated in person for the Applicant

Kevin Smith, Claims Representative, from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 704.60**, was AMENDED and permitted by the arbitrator at the oral hearing.

Amount in dispute amended to \$528.45, in accordance with the proper rate of reimbursement for the MRI at issue under the Fee Schedule, since a lumbar spine MRI was performed on the same day of service.

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

3. Summary of Issues in Dispute

Whether a right hand MRI was medically necessary.

This is a claim for reimbursement for a right hand MRI performed on September 1, 2015, following an automobile accident which occurred on July 10, 2015.

Respondent denied the claim based on lack of medical necessity. Specifically, Respondent denied the claim based on the peer review of internal medicine doctor Kevin Curley, M.D., dated November 2, 2015.

4. Findings, Conclusions, and Basis Therefor

The findings herein are based on documentary evidence set forth in the ADR Center submitted by the parties prior to the date of hearing and oral argument at the hearing.

An Applicant establishes a *prima facie* showing of entitlement to No-Fault benefits under Article 51 of the Insurance Law by submitting proof that it submitted a claim setting forth the fact and the amount of the loss sustained and payment of No-Fault benefits was overdue. A.B. Med. Servs., PLLC v. Liberty Mutual Ins. Co., 39 A.D.3d 779 (2d Dep't 2007); Nyack Hosp. v. Metro. Prop. & Cas. Ins. Co., 16 A.D.3d 564 (2d Dep't 2005); Mary Immaculate Hospital v. Allstate Insurance Co., 5 AD3d 742 (2d Dep't 2004).

Once Applicant makes a *prima facie* showing, the burden shifts to Respondent. Respondent's denial for lack of medical necessity must be supported by competent medical evidence setting forth a clear factual basis and medical rationale for denying the claim. Citywide Social Work, & Psy. Serv. P.L.L.C. v. Travelers Indemnity Co., 3 Misc.3d 608 (Civ. Ct. Kings Co. 2004).

To successfully support its denial, Respondent's peer review must address all pertinent objective findings contained in Applicant's medical submission and set forth how and why the disputed services were inconsistent with generally accepted medical practices. The conclusory opinions of the peer reviewer, standing alone and without support of medical authorities, will not be considered sufficient to establish the absence of medical necessity. *See* Citywide Social Work, & Psy. Serv. P.L.L.C. v. Travelers Indemnity Co., supra; Amaze Medical Supply, Inc. v. Eagle Insurance Co., 2 Misc. 3d 128A, 784 NYS2d 918 (App Term 2d & 11th Jud Dists.).

Where a Respondent meets its burden, it becomes incumbent on the claimant to rebut the peer review. Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 139(A), 2008 WL 506180 (App. Term 2d & 11th Dists. Feb. 21, 2008); A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co., 16 Misc.3d 131(A), 2007 WL 1989432 (App. Term 2d & 11th Dists July 3, 2007).

"[T]he insured/provider bears the burden of persuasion on the question of medical necessity. Specifically, once the insurer makes a sufficient showing to carry its burden of coming forward with evidence of lack of medical necessity, 'plaintiff must rebut it or

succumb." Bedford Park Medical Practice, P.C. v. American Transit Ins. Co., 8 Misc.3d 1025(A), 2005 WL 1936346 at 3 (Civ. Ct. Kings Co., Jack M. Battaglia, J., Aug. 12, 2005). "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), 2006 N.Y. Slip. Op. 5187(U) at 2, 2006 WL 2829826 (App. Term 2d & 11th Dists. Sept. 29, 2006).

The EIP was a 30-year-old female who was the seat-belted, front-seat passenger in a vehicle involved in a motor vehicle accident on July 10, 2015. The EIP sustained back, right knee, and right hand injuries in the accident. Following the accident, the EIP was brought to a local emergency room, where she was evaluated, treated, and released. On July 13, 2015, the EIP came under the care of chiropractor Michael Jeanniton, D.C. Examination revealed decreased muscle strength and moderate distress due to pain. On July 20, 2015, the EIP presented to Gamil Kostandy, M.D., for evaluation. Right hand examination revealed decreased ranges of motion and decreased muscle strength of 4/5. Following evaluation, the EIP began a course of conservative treatment. On September 1, 2015, after undergoing a reevaluation on August 31, 2015, the EIP underwent the right hand MRI at issue in this hearing. The testing was performed almost two months after the accident.

It is undisputed that Applicant established its *prima facie* case of entitlement to first-party no-fault benefits by demonstrating it submitted a timely claim setting forth the fact and amount of loss sustained and payment for the claim has not been made.

The burden shifts to Respondent to set forth a clear factual basis and medical rationale for denying the claim. Respondent attempts to meet its burden through the peer review of internal medicine doctor Kevin Curley, M.D., dated November 2, 2015. Dr. Curley claims the MRI was unnecessary because examination on August 31, 2015, revealed hand strength to be within normal limits and no specific abnormalities were documented related to the right hand. Dr. Curley argues the MRI was ordered and performed despite the lack of evidence of a full and complete hand evaluation and indications for hand MRI's are to assess for early vascular necrosis, tumors, soft tissue lesions, or subtle ligamentous disruptions, which were absent under the instant circumstances.

In rebuttal, Applicant provided a report from Gamil Kostandy, M.D., the EIP's treating physician. After outlining the evaluation findings related to treatment rendered to the EIP following the accident, Dr. Kostandy claims the right hand MRI at issue was necessary to plan the treatment in light of the findings of decreased ranges of motion and decreased hand muscle strength. Dr. Kostandy cites the American College of Radiology and New York State Workers' Compensation Board New York Medical Treatment Guidelines and explains why he believes the EIP met the criteria for performance of the testing.

After review of the medical records included on the ADR Center and consideration of the arguments advanced by counsel from both parties, assuming *arguendo* that Dr. Curley's peer review set forth a clear factual basis and medical rationale to recommend

against reimbursement for the MRI at issue, I conclude that Applicant met its burden in rebuttal. Dr. Kostandy's rebuttal addressed the arguments advanced by Dr. Curley and presented affirmative evidence in support of the medical necessity for the testing. The testing was performed after the EIP demonstrated continued hand difficulties, substantiated by positive objective findings, over a period of almost two months following the accident. Given the EIP's treating physician's recommendation for the EIP to undergo the testing, which is supported by objective findings, I defer to the treating provider's determination that the testing was necessary for the EIP's rehabilitation following the accident. *See James M. Liguori, Physician, vs. State Farm Mut.Auto Ins.*, 15 Misc.3d 1103A, 836 N.Y.S.2d 499, (District Ct. Nassau Co., 2007).

Based on the foregoing, I find that Applicant is entitled to reimbursement for the testing at issue and is awarded the claim, in the amount of \$528.45, representing the amended amount in dispute and proper rate of reimbursement for the MRI at issue under the Fee Schedule, since a lumbar spine MRI was performed on the same day of service.

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	Amount Amended	Status
	Westchester	09/01/15 -	\$704.60	\$528.45	Awarded:

	Radiology & Imaging PC	09/01/15			\$528.45
Total			\$704.60		Awarded: \$528.45

- B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 03/09/2016, which is a relevant date only to the extent set forth below.)

Where a claim is untimely denied, or not denied or paid, interest shall accrue as of the 30th day following the date the claim is presented by the claimant to the insurer for payment. Where a claim is timely denied, interest shall accrue as of the date an action is commenced or an arbitration requested, unless an action is commenced or an arbitration requested within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. (11 NYCRR 65-3.9(c)). The end date for the calculation of interest shall be the date of payment of the claim. In calculating interest, the date of accrual shall be excluded from the calculation. Where a motor vehicle accident occurs after April 5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. (11 NYCRR 65-3.9(a)).

C. Attorney's Fees

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

For cases filed prior to February 4, 2015, 20 percent of the amount of first party benefits awarded herein, plus interest thereon, subject to a minimum of \$60 and a maximum of \$850. For cases filed on or after February 4, 2015, 20 percent of the amount of first party benefits awarded herein, plus interest thereon, subject to no minimum and a maximum of \$1360. (11 NYCRR 65-4).

- 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 New York
SS :
County of Nassau

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

06/03/2017
(Dated)

Eylan Schulman

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:
c9e409c885e81c9147251863b278f5eb

Electronically Signed

Your name: Eylan Schulman
Signed on: 06/03/2017