

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Jeff Mollins DC  
(Applicant)

- and -

Hereford Insurance Company  
(Respondent)

AAA Case No.	17-16-1029-3181
Applicant's File No.	209750
Insurer's Claim File No.	50511-03
NAIC No.	24309

**ARBITRATION AWARD**

I, Elyse Balzer, 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: AF-B

1. Hearing(s) held on 06/12/2017  
Declared closed by the arbitrator on 06/12/2017

K. Lundgren, Esq from Thwaites, Lundgren & D'Arcy Esqs participated in person for the Applicant

Thomas Wolf, Esq. from Law Offices of Rubin & Nazarian participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 3,560.85**, was AMENDED and permitted by the arbitrator at the oral hearing.

At the hearing the claim was amended to \$2952.75.

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

3. Summary of Issues in Dispute

t the hearing the claim was amended to \$2952.75.

The accident happened on 7/2/14.

The claim is for chiropractic services performed between 10/3/14 and 9/28/15.

At the hearing applicant withdrew the claim for services performed between 12/10/14 and 1/5/15.

The issues are:

Has applicant presented submission of its bill for services performed between 12/1/14 and 12/3/14?

Has respondent proven that it properly paid applicant for services performed between 10/3/14 and 10/22/14?

Has respondent proven the lack of medical necessity for services denied based on a chiropractic IME?

All the documents in the ADR Center record of the case maintained by the AAA at the time of the hearing were reviewed.

#### 4. Findings, Conclusions, and Basis Therefor

The 33 year old female injured person AF-B was in a vehicular accident, as a back seat passenger, on 7/2/14. The accident happened at Bleecker Street & Mercer Street in Manhattan. AF-B was taken by ambulance to Bellevue Hospital.

##### Submission of bill

Respondent claimed that it did not receive applicant's bill for dates of service 12/1 & 12/3/14.

Applicant presented proof of mailing in the form of a USPS form 3877 mailing list. Item 5 listed AF-B's name, respondent's name & address, the claim number and the dates of service. The mailing list is postmarked 12/19/14 which evinces proof that the US Postal Service actually accepted applicant's bill for mailing.

Respondent has not presented any proof to contradict applicant's proof of mailing.

Based on the evidence, I find that applicant has proven timely submission of mailing of the bill to respondent.

Applicant is awarded reimbursement for these dates of service.

##### Fee schedule

Respondent reduced payment for applicant's services performed between 10/3/14 & 10/22/14.

For certain dates of service respondent paid the maximum allowable daily allowance for chiropractic & physical therapy performed on a day, i.e \$46.24 per day.

Respondent reduced payment of the physical therapy portion of the bill due to the "8 unit rule."

Chapter 8 of the NYS Workers' Compensation Fee Schedule contains "Physical Medicine Ground Rules."

Ground Rule 11 states:

**Multiple Physical Medicine Procedures and Modalities**

When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 8.0 units or the amount billed, whichever is less. The following codes represent the physical medicine procedures and modalities subject to this rule:

97010 97012 97014 97016 97018 97022 97024 97026 97028  
97032 97033 97934 97035 97036 97039 97110 97112 97113  
97116 97124 97139 97140 97950 97530 97535 97537 97542  
97760 97761 97762

The applicable ground rule (Ground Rule 11, Chap. 8, Physical Medicine, NYS Workers' Compensation Fee Schedule) lists the CPT codes which are subject to the maximum reimbursement of 8.0 units for modalities/procedures performed on the same day.

Respondent did not present proof of payment for 2 dates of service, 10/3/14 & 10/8/14.

Based on the evidence, I find that respondent owes \$39.66 for these two dates of service.

Medical necessity

On 11/6/14 AF-B had an orthopedic IME with Dr. Robert Y. Pick, MD and a chiropractic/acupuncture IME with Dr. John Iozzio, D.C.

The chiropractic IME report noted that AF-B was accompanied by a translator. AF-B's complaints after the accident were of pain in the head, nose, lips & forehead. AF-B began thrice weekly acupuncture, chiropractic and physical therapy treatments on 7/14/14. AF-B underwent MRI testing. AF-B stated that her treatments were helpful.

At the chiropractic IME AF-B complained of neck pain, and low back pain which radiated to the legs when standing or sitting. AF-B complained of pain in the right elbow, left hand & right knee & numbness in the left index & middle finger. AF-B complained of headaches and trouble breathing.

The chiropractic IME listed the records which were reviewed, which did not include any MRI reports and did not include any chiropractic treatment notes or reports.

The chiropractic IME report noted "minimal complaints" of tenderness in the cervical spine, no muscle spasm, decreased cervical range of motion, negative clinical tests, normal sensation, normal reflexes & normal muscle strength. The cervical spine, lumbar spine, both shoulders, the left wrist, both hips, both knees, both ankles, both feet and both elbows were examined.

On 11/6/14 Dr. Iozzio concluded that AF-B had resolved lumbar sprain & resolving cervical spine strains. He also concluded that AF-B had resolved right elbow sprain, left hand sprain, and right knee sprain. It is unclear why he expressed his opinion about AF-B's joint injuries since as a chiropractor he does not have a license to treat those areas of the body.

Dr. Iozzio concluded that AF-B had a mild disability of the cervical spine and that she needed 6 weeks of chiropractic treatment (2 times a week) with a re-evaluation.

On 12/18/14 AF-B had a re-examination IME with Dr. Iozzio. The report of this IME does not show that any new medical records were reviewed. Dr. Iozzio did not review any chiropractic treatment records or any chiropractic reports. This IME was reported as entirely normal. Dr. Iozzio concluded that AF-B's cervical spine sprain/strain was resolved and he deferred evaluation of the right elbow, left hand & right knee to the appropriate specialty. Dr. Iozzio found there was no need for chiropractic care.

Applicant submitted his own rebuttal to the IMEs.

Applicant related the details of his initial chiropractic exam of AF-B on 7/14/14. There were many positive findings and applicant recommended chiropractic treatment. Applicant related the results of the cervical MRI which showed disc herniations at multiple levels with impingement. Applicant related the results of the lumbar MRI which showed disc herniation with impingement at L5-S1 and bulging at L3-L4 and L4-L5. Applicant pointed out that the complaints made by AF-B at the IMEs (pain, radiation & numbness) contradicted the IME findings and that his progress notes showed pain complaints on 12/17/14, 12/18/14 & 2/18/15, both before and after the IMEs. Applicant stated that it was clear that AF-B benefitted from chiropractic treatment and that it was medically necessary to return her to her previous range of motion, strength & quality of life.

Respondent submitted an addendum from Dr. Iozzio. Dr. Iozzio tried to dismiss the findings of the MRIs by claiming that "it is well known that abnormalities identified on MRI are commonly found on asymptomatic persons and unless clinically correlated with objective findings provide little in the way of treatment planning value." This statement is contradicted by the clinically correlated complaints of numbness in the left hand which clearly correlated with the positive findings of the cervical MRI. The idea that those complaints were "subjective", or due to "soft tissue strain/sprain injuries as labeled

by Dr. Iozzio, is unacceptable in view of the neutrality of MRI testing and the medical significance of such testing and the persistence of the numbness symptoms.

Respondent bears "both the burden of production and the burden of persuasion with respect to the medical necessity of the treatment or testing for which payment is sought." See, Bajaj v. Progressive Ins. Co., 14 Misc 3d 1202(A) (N.Y.C. Civ. Ct. 2006). The quantum of proof necessary to meet respondent's burden, at the bare minimum, is to "establish a factual basis and medical rationale for the lack of medical necessity of plaintiff's services." A.B. Medical Services, PLLC v. NY Central Mutual Fire Ins. Co., 7 Misc 3d 1018(A), 801 N.Y.S., 2d 229 (Civil Ct. Kings. Co. 2005).

Once a defendant makes out a prima facie case that services were not medically necessary the burden shifts to plaintiff to establish the existence of a triable issue of fact. See, I & B Surgical Supply aao Jean Elie v. NY Central Mut. Fire Ins. Co., 2007 NY Slip 27159, 16 Misc.3d 4 (App Term, 2nd & 11th Jud Dists, 2nd Dep't 2007).

Applicant has, in my opinion, successfully rebutted & refuted respondent's proof, and has done so by a fair preponderance of the evidence. See, c.f., Exclusive Med. Supply Inc. v. Mercury Ins. Group, 2009 NY Slip Op 52273(U), 25 Misc.3d 136 (A) (App Tm, 2nd Dep't 11/5/09); Delta Diagnostic Radiology P.C. v. American Tr. Ins. Co., 18 Misc.3d 128[A], 2007 N.Y. Slip Op 5255[U]; A.Khodadadi Radiology P.C. v. N.Y. Cent. Mut. Fire Ins. Co., 16 Misc.3d 14 [A], 2007 N.Y. Slip Op 51342[U] (App Tm, 2d & 11th Jud Dists 2007); Eagle Surgical Supply Inc. Progressive Cas.Ins. Co., 2008 NY Slip Op 50534(U), (App Tm, 2nd & 11th Jud Dists, 2008); West Tremont P.C. v. GEICO, 2006 N.Y. Slip Op 51871 (U), (App Tm, 2nd & 11th Jud Dists, 2006). See, also, I & B Surgical Supply aao Jean Elie v. NY Central Mut. Fire Ins. Co., 2007 NY Slip 27159, 16 Misc.3d 4, (App Term, 2nd & 11th Jud Dists, 2nd Dep't).

### Conclusion

Applicant is awarded \$2952.75.

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
	Jeff Mollins DC	10/03/14 - 09/28/15	\$3,560.85	\$2,952.75	Awarded: \$2,952.75
Total			\$3,560.85		Awarded: \$2,952.75

- B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 03/17/2016, which is a relevant date only to the extent set forth below.)

From 3/17/16 to date of payment of the award

C. Attorney's Fees

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

In cases filed before 2/4/15, the Respondent shall pay the Applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(e)(effective April 5, 2002). For cases filed after 2/4/15, the respondent shall pay the Applicant an attorney's fee in accordance with newly promulgated 11 NYCRR 65-4.6 (d), as amended by the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D).

- 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 Westchester

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

07/02/2017  
(Dated)

Elyse Balzer

### **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:**

4d41349792948e0bca5a345cd7eaf115

### **Electronically Signed**

Your name: Elyse Balzer  
Signed on: 07/02/2017