

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

DHD Medical, P.C.
(Applicant)

- and -

Tri-State Consumer Insurance Company
(Respondent)

AAA Case No. 17-16-1037-1726

Applicant's File No. 38527

Insurer's Claim File No. 01071179PIP01

NAIC No. 23060

ARBITRATION AWARD

I, Dinsmore Campbell, 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: Claimant

1. Hearing(s) held on 06/14/2017
Declared closed by the arbitrator on 06/14/2017

Dayva Zaccaria, Esq. from Law Office of Gewurz & Zaccaria, PC participated in person for the Applicant

Rikki Studley, Esq. from Karen J. Breslow Attorney at Law participated in person for the Respondent

2. The amount claimed in the Arbitration Request, \$ **1,822.24**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

The parties stipulated that the applicant established its prima facie case of entitlement to No-Fault benefits and that the respondent's NF-10/Denial of Claim forms were timely issued in accordance with 11 NYCRR 65-3.8(a)(1), and that fees comport with the fee schedule.

3. Summary of Issues in Dispute

The claimant, a 19 year-old male, was involved in a motor vehicle accident on 10/12/15, as a bicyclist. Thereafter, the claimant sought medical attention for the injuries sustained

in the accident. This dispute arises from a claim for physical therapy services, and office visits rendered 1/11/16 through 4/1/16. Respondent denied the claim based on an IME conducted by J. Serge Parisien, M.D., on 12/10/15, with an effective cutoff date of 1/3/16. The issue to be decided is whether the respondent's lack of medical necessity defense can be sustained.

4. Findings, Conclusions, and Basis Therefor

This case was decided on the submissions of the parties as contained in the Electronic Case Folder maintained by the American Arbitration Association and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in the ECF for both parties and make my decision in reliance thereon.

A denial premised on lack of medical necessity must be supported by competent evidence such as an independent medical examination, peer review or other proof which sets forth a factual basis and medical rationale for denying the claim. See, Healing Hands Chiropractic, P.C. v. Nationwide Assur. Co., 5 Misc3d 975 (2004).

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 2009 NY Slip Op 00351 (App Div 2d Dep't., Jan. 20, 2009); Channel Chiropractic, P.C. v. CountryWide Ins. Co., 2007 Slip Op 01973, 38 A.D.3d 294 (1st Dep't. 2007); Bronx Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co., 2007 NY Slip Op 27427, 17 Misc.3d 97 (App Term 1st Dep't., 2007), such as by a qualified expert performing an independent medical examination, conducting a peer review of the injured person's treatment, or reconstructing the accident. Id.

The trial courts have held that a peer review report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. See generally, Nir v. Allstate Ins. Co., 7 Misc.3d 544, 547, 796 N.Y.S.2d 857, 860 (Civ. Ct. Kings Co. 2005); See also, All Boro Psychological Servs. P.C. v. GEICO, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012).

In support of its lack of medical necessity defense, the respondent relies upon an IME by Dr. Parisien conducted on 12/10/15 with an effective cutoff date of 1/3/16.

At the time of the examination, the claimant complained of pain in his neck, right shoulder and left ankle, for which he was receiving physical therapy and massage therapy. However, Dr. Parisien submitted that there was no objective evidence of a disability. Accordingly, there was no need for orthopedic treatment including physical therapy. In fact, he submitted that the claimant could continue to work without restrictions or boundaries stemming from the accident. The records reflect that Dr.

Parisien performed a comprehensive examination of the claimant without any indications of abnormalities or neurological deficits.

Where the IME report submitted by the insurer sets forth a factual basis and medical rationale for the conclusion that the assignor's injuries were resolved, and that the treatment which is the subject of the claim, lacked medical necessity, the report submitted in opposition must meaningfully refer to, or rebut the IME findings. Premier Health Choice Chiropractic, P.C. v. Praetorian Ins. Co., 41 Misc. 3d 133(A), 981 N.Y.S 2d 638 (Table), 2013 N.Y. Slip Op 51802 (U), 2013 WL 5861532 (App. Term 1st Dept. Oct 30, 2013).

Accordingly, the burden now shifts to the applicant who has the ultimate burden of persuasion. The applicant did not provide a formal rebuttal, but relies upon its contemporaneous treatment reports. Indeed, on the 12/4/15 follow-up evaluation, Alfredo Davila-Rivera, M.D., one of the treating physicians, notes decreased range of motion on the cervical spine, tenderness to palpation on bilateral trapezius and cervical paraspinal muscles. The examination of the lumbar spine revealed tenderness to palpation and reduced range of motion as well. The Straight leg raising test in the sitting position created some discomfort bilaterally. In the examination of the right shoulder, range of motion was reduced and the Hawkins and Neers examination created pain.

On the follow-up evaluations on 1/15/16 and 2/19/16, the claimant showed signs of improvement but remained symptomatic. Further, on an orthopedic report by Howard I. Baum, M.D., the claimant also showed signs of improvement, but range of motion measurements were reduced.

The applicant also contends that since the IME was done less than two months after the accident, the findings in the IME report are tenuous and unable to sustain the respondent's lack of medical necessity defense.

After reviewing the pertinent record, and after careful consideration of the parties' oral arguments, the undersigned finds that the applicant was able to refute the IME findings. Although the IME doctor recommended no further treatment, the treatment reports revealed positive findings that were not adequately reconciled by the IME doctor. Coupled with the claimant's subjective complaints of pain, the undersigned finds that the respondent has failed to submit sufficient evidence to establish, prima facie its lack of medical necessity defense.

Accordingly, the applicant's claim is granted.

Any further issues raised in the record are held to be moot and/or waived insofar as not raised at the time of the hearing.

This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator.

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	Status
	DHD Medical, P.C.	01/11/16 - 04/01/16	\$1,822.24	Awarded: \$1,822.24
Total			\$1,822.24	Awarded: \$1,822.24

- B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 06/17/2016, which is a relevant date only to the extent set forth below.)

Applicant is awarded interest pursuant to the No-Fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30-day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. "If an applicant does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or payment of benefits calculated pursuant to Department of Financial Services regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken." 11 NYCRR §65-3.9(c).

The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009).

C. Attorney's Fees

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

As the claim was filed subsequent to the Sixth Amendment to 11 NYCRR §65-4 (Insurance Regulation 68-D) which took effect on February 4, 2015, Attorney's Fees shall be calculated pursuant to the amended terms, as follows: 20 percent of the amount of first-party benefits, plus interest thereon, subject to a maximum fee of \$1,360. [11 NYCRR §65-4.6(d)]. There is no minimum fee.

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

07/07/2017
(Dated)

Dinsmore Campbell

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:
691bd0c2e567fb48fae7acb0382f8a94

Electronically Signed

Your name: Dinsmore Campbell
Signed on: 07/07/2017