

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

NY Manhattan Med PLLC
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-16-1041-0532
Applicant's File No.	A07342
Insurer's Claim File No.	0174007820101140
NAIC No.	35882

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 ["AZ"]

1. Hearing(s) held on 10/02/2017
Declared closed by the arbitrator on 10/02/2017

Andrew Bruskin, Esq., from Munawar & Andrews-Santillo LLP participated in person for the Applicant

Jerry Marino from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 879.73**, 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 bill. They also stipulated that Respondent's Form NF-10 denial of claim form was 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 a cervical spine MRI performed on Assignor
- Whether Respondent made out a prima facie case of lack of medical necessity and, if so, whether Applicant rebutted it

4. Findings, Conclusions, and Basis Therefor

Appearances

For Applicant:

Munawar & Andrews-Santillo LLP
420 Lexington Avenue
Suite 2601
New York, NY 10170
By: Andrew Bruskin, Esq.

For Respondent:

Jerry Marino
GEICO Insurance Co.
750 Woodbury Road
Woodbury, NY 11797

Applicant commenced this New York No-Fault insurance arbitration, seeking as compensation \$879.73 which it billed for performing a cervical spine MRI on Nov. 2, 2015, on Assignor, a 21-year-old male who was injured in a motor vehicle accident on Sept. 26, 2015. Respondent denied payment on two grounds: fees not in accordance with fee schedule and lack of medical necessity. At the hearing, Respondent stated that it was not pursuing the fee defense; only lack of medical necessity.

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. Respondent's peer review is addendum remains precluded from the record due to its late submission.

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

Since Respondent's denial was timely (as stipulated by the parties), it was within its rights to assert lack of medical necessity 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. Zablocki, 257 A.D.2d 506 (1st Dept. 1999). "The no-fault law defines 'basic economic loss,' for which accident victims are entitled to reimbursement up to \$50,000, as '[a]ll necessary expenses incurred for: (i) medical, hospital ... surgical, nursing, dental, ambulance, x-ray, prescription drug and prosthetic services' (Insurance Law § 5102[a][1] [emphasis added]). Like the statute, the regulations promulgated thereunder expressly state that reimbursable medical expenses consist of 'necessary expenses' (11 NYCRR 65-1-1 [emphasis added])." Long Island Radiology v. Allstate Ins. Co., 36 A.D.3d 763, 765 (2d Dept. 2007).

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) (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) (App. Term 2d & 11th Dists. Apr. 1, 2003). In fact, without a peer review, a defense of lack of medical necessity at the litigation stage cannot survive. See A.B. Medical Services PLLC v. Lumbermens Mutual Casualty Co., 4 Misc.3d 86 (App. Term 2d Dept. 2004).

A peer reviewer must establish a factual basis and medical rationale for his asserted lack of medical necessity of the health care provider's services. See Amaze Medical Supply Inc. v. Allstate Ins. Co., 12 Misc.3d 142(A), 2006 N.Y. Slip Op. 51412(U) (App. Term 2d & 11th Dists. July 12, 2006); Prime Psychological Services, P.C. v. Progressive Casualty Ins. Co., 24 Misc.3d 1244(A), 2009 N.Y. Slip Op. 51868(U) at 3 (Civ. Ct. Richmond Co., Katherine A. Levine, J., Aug. 5, 2009); A.M. Medical Services, P.C. v. Deerbrook Ins. Co., 18 Misc.3d 1139(A), 2008 N.Y. Slip Op. 50368(U) (Civ. Ct. Kings Co., Sylvia G. Ash, J., Feb. 25, 2008).

"A no-fault insurer defending a denial of first-party benefits on the ground that the billed-for services were not 'medically necessary' must at least show that the services were inconsistent with generally accepted medical / professional practice. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden of proving that the services were not 'medically necessary'." CityWide Social Work & Psy. Serv., P.L.L.C. v. Travelers Indemnity Co., 3 Misc.3d

608, 609 (Civ. Ct. Kings Co. 2004). "Generally accepted practice is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." *Id.* at 616; accord, Prime Psychological Services, P.C. v. Progressive Casualty Ins. Co., *supra*; Millennium Radiology, P.C. v. New York Central Mutual Fire Ins. Co., 23 Misc.3d 1121(A), 2009 N.Y. Slip Op. 50877(U) (Civ. Ct. Richmond Co., Katherine A. Levine, J., Apr. 30, 2009). Without a recitation to generally accepted medical practice, a peer reviewer's opinion is simply a different professional judgment which, in and of itself, does not establish that the disputed services were medically unnecessary to treat the injured person's condition.

If the peer review satisfies these standards, it becomes incumbent on the claimant to rebut the peer review. *See Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co.*, 18 Misc.3d 139(A), 2008 N.Y. Slip Op. 50346(U) (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 N.Y. Slip Op. 51342(U) (App. Term 2d & 11th Dists. July 3, 2007), because the ultimate burden of proof on the issue of medical necessity lies with the claimant. *See Insurance Law* § 5102; 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). "[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 N.Y. Slip Op. 51282(U) at 3 (Civ. Ct. Kings Co., Jack M. Battaglia, J., Aug. 12, 2005). Assuming the insurer establishes a lack of medical necessity, it is ultimately the claimant who must prove, by a preponderance of the evidence, that the services or supplies were medically necessary. Dayan v. Allstate Ins. Co., 49 Misc.3d 151(A), 2015 N.Y. Slip Op. 51751(U) (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. (App. Term 2d, 11th & 13th Dists. 2012).

"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. 51871(U) at 2 (App. Term 2d & 11th Dists. Sept. 29, 2006). Thus, although Respondent must come forward with prima facie proof of lack of medical necessity, the burden will shift to Applicant to prove medical necessity by a preponderance of the credible evidence if Respondent meets its burden.

The peer review relied upon by Respondent in asserting lack of medical necessity was prepared by Dr. Dominick Garofalo, D.C. At the outset he listed the various medical records pertaining to Assignor's post-accident treatment. He then noted that Assignor was involved in a motor vehicle accident on Sept. 26, 2015. On Sept. 30, 2015, Assignor presented to a chiropractor for examination, complaining of

neck pain. The pertinent examination findings included decreased cervical spine ranges of motion. There was positive orthopedic testing of the cervical spine. Deep tendon reflex deficits to the upper extremities were documented. However, on Nov. 10, 2015, Dr. Mitchell Horowitz, M.D., documented a normal neurological assessment of the upper extremities.

"Cervical spine MRIs are reserved for patients who have persistent focal neurological deficits despite undergoing six weeks of conservative therapy," wrote Dr. Garofalo. "Likewise, they are reserved for patients in whom surgical or interventional therapy is being considered. The medical records available for my review are devoid of either scenario." Dr. Garofalo also observed that there was no indication that the MRI results impacted the course of chiropractic treatment. As part of his analysis, Dr. Garofalo cited to three medical authorities.

Dr. Garofalo's conclusion was that the subject cervical spine MRI was not medically necessary.

As noted above, the case law requires that a peer review contain a factual basis and a medical rationale. I find that Dr. Garofalo's contained both. The medical records afforded him a factual basis. As for the medical rationale, it is true that he did not use the talismanic phrase "generally accepted medical standards," but that is not required in order to convey what those standards are. Prime Psychological Services, P.C. v. Progressive Casualty Ins. Co., 2009 N.Y. Slip Op. 51868(U) at 5, 2009 WL 2780152 (Civ. Ct. Richmond Co., Katherine A. Levine, J., Aug. 5, 2009). By citing to numerous medical authorities he conveyed that he was applying generally accepted medical practice. Therefore, I find further that the peer review established a lack of medical necessity for Respondent. Per the case law, the burden of proof shifted to Applicant to rebut the peer view and affirmatively prove medical necessity.

Applicant relied upon a rebuttal by Dr. Muhammad Asad Mirza, its owner. He stated that he was familiar with guidelines and journals regarding the need for MRIs. He wrote that he reviewed the "file for patient AZ," but did not list them as did Dr. Garofalo. Assignor presented to Dr. Angelo DiMaggio on Sept. 30, 2015, wrote Dr. Mirza. There was tenderness upon palpation and muscle spasms. Decreased range of motion was present and the following tests were positive: Shoulder Depression, Soto-Hall, Distraction, Jackson's Linder's, and Valsalva. Assignor had decreased muscle strength and DTRs were decreased at C5-6 root.

Dr. Mirza disputed the standard specified by Dr. Garofalo -- that there be six weeks of persistent neurological deficits. He claimed that other standards supported the decision to pursue a cervical spine MRI. He claimed that his analysis was in accordance with the American Medical Association's definition of medical necessity, which is that services be those that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating a condition in a manner which is (1) in accordance with generally accepted standards of medical practice, (2)

clinically appropriate in terms of type, frequency, extent, site, and duration, and (3) not primarily for the convenience of the patient, physician, or other health care provider.

The problem with Dr. Mirza's analysis is that it is his analysis -- not that of the prescribing doctor -- Angelo DiMaggio. A necessary medical expense under the No-Fault Law is one incurred for a treatment, procedure, or service ordered by a qualified physician based on the physician's objectively reasonable belief that it will further the patient's diagnosis and treatment. The use of the treatment, procedure, or service must be warranted by the circumstances and its medical value must be verified by credible and reliable evidence. Medical Expertise, P.C. v. Trumbull Ins. Co., 196 Misc.2d 389 (Civ. Ct. Queens Co. 2003). In this case, however, we have no evidence of the objectively reasonable belief of Dr. DiMaggio that the MRI would further the patient's diagnosis. That is because there is no report or rebuttal from Dr. DiMaggio explaining why he ordered the MRI. What Dr. Mirza is doing is retroactively attempting to justify its performance -- in effect speculating why Dr. DiMaggio ordered it.

The Sept. 30, 2015 exam report bears Dr. DiMaggio's name at the end, but he did not sign it. The report says nothing about an MRI. Dr. Horowitz examined Assignor on Sept. 29, 2015, and recorded normal muscle strength, normal deep tendon reflexes, and sensation within normal limits. This leads me to question the accuracy of any findings by Dr. DiMaggio that on Sept. 30, 2015, Assignor had decreased muscle strength and DTRs were decreased at C5-6 root. These latter, questionable findings were relied upon by Dr. Mirza. Dr. Horowitz's checklist exam report contained an option to circle an MRI of the cervical spine, but he did not do so, indicating to me that one was not necessary.

On balance, I find that that peer review of Dr. Garofalo was more credible and probative than the evidence submitted by Applicant. I find that the cervical spine MRI was not medically necessary. I sustain the defense of lack of medical necessity asserted in Respondent's Form NF-10 denial.. 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.

This arbitrator has not made a determination that benefits provided for under Article 51 (the No-Fault statute) of the Insurance Law are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of Assignor. As such and in accordance with the provisions of the prescribed NYS Form NF-AOB (the assignment of benefits), Applicant health provider shall not pursue payment directly from Assignor for services which were the subject of this arbitration, notwithstanding any other agreement to the contrary.

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.

10/15/2017
(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:
4f5495c1a7bb7674e629ed48ced50ec5

Electronically Signed

Your name: Aaron Maslow
Signed on: 10/15/2017