

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Emis Chiropractic P.C.
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No. 17-17-1055-1610

Applicant's File No.

Insurer's Claim File No. 0028966670101096

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 ["SF"]

1. Hearing(s) held on 11/06/2017
Declared closed by the arbitrator on 11/06/2017

Walter Pisary, Esq., from Ratsenberg & Associates, P.C. participated in person for the Applicant

Jaime Orlando from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,274.89**, 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 bills. They also stipulated that Respondent's Form NF-10 denial of claim forms were 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 chiropractic performed on Assignor past an IME cutoff of benefits
- Whether Respondent made out a prima facie case of lack of medical necessity for further chiropractic past the IME cutoff and, if so, whether Applicant rebutted it

4. Findings, Conclusions, and Basis Therefor

Appearances

For Applicant:

Ratsenberg & Associates, P.C.
2387 Ocean Avenue
Apt. 1G
Brooklyn, NY 11229
Of counsel: Walter Pisary, Esq.

For Respondent:

Jaime Orlando
Claims Representative
GEICO
750 Woodbury Road
Woodbury, NY 11797

Applicant commenced this New York No-Fault insurance arbitration, seeking as compensation \$1,274.89 which it billed for performing chiropractic from June 14, 2016 to Nov. 3, 2016 on Assignor, a 26-year-old female who was injured in a motor vehicle accident on April 13, 2016. Respondent denied payment of the six bills at issue on the basis of an IEM cutoff imposed effective July 1, 2016.

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 with the exception that the additional submission by Applicant on July 20, 2017 remains precluded. Per the No-Fault Regulations, at 11 NYCRR 65-4.5(o)(iii)(2), I determined whether the parties provided and exchanged documents in accordance with the requirements of the "Rocket Docket" rule (11 NYCRR 65-4.2(b)(3)), which requires that an applicant submit and serve its evidentiary documents upon submitting and serving the arbitration request form, and that a respondent submit and file its evidentiary documents within 30 days of being advised by the designated arbitration association of the applicant's submission. I noted at the hearing that this additional submission was late. Applicant's July 20, 2017 submission was more than five months late -- after its original submission of Feb. 6, 2017.

There must be finality to the submission of documents. I find no extraordinary reason to accept these late submissions. They are violative of the "Rocket Docket" rule embodied in the regulations promulgated by the State Insurance Department (now the Financial Services Department). A No-Fault arbitrator acts within her discretion in refusing to entertain late submissions. E.g., Matter of Global Liberty Ins. Co. v. Coastal Anesthesia Services, LLC, 145 A.D.3d 644 (1st Dept. 2016) (four days late, per arbitration award in AAA Case No. 17-14-9048-0690); Matter of Mercury Casualty Co. v. Healthmakers Medical Group, P.C., 67 A.D.3d 1017 (2d Dept. 2009) (27 days late, per briefs).

The parties stipulated that Applicant established a prima facie case of entitlement to No-Fault compensation with respect to its bills. They also stipulated that Respondent's Form NF-10 denial of claim forms were 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 denials were timely, it was within its rights to assert lack of medical necessity for further treatment 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, 684 N.Y.S.2d 229 (1st Dept. 1999).

An IME doctor must establish a factual basis and medical rationale for his asserted lack of medical necessity of further health care services. E.g., Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), 2008 WL 4222084 (App. Term 2d & 11th Dists. Sept. 3, 2008). If he does so, it becomes incumbent on the claimant to rebut the IME review, see AJS Chiropractic, P.C. v. Mercury Ins. Co., 2009 WL 323421 (App. Term 2d & 11th Dist. Feb. 9, 2002), because the ultimate burden of proof on the issue of medical necessity lies with the claimant. See Insurance Law § 5102; Wagner v. Baird, 208 A.D.2d 1087, 617 N.Y.S.2d 919 (3d Dept. 1994); 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). The insured or the provider bears the burden of persuasion on the question of medical necessity. Bedford Park Medical Practice P.C.

v. American Transit Ins. Co., 8 Misc.3d 1025(A), 806 N.Y.S.2d 443 (Table), 2005 WL 1936346 (Civ. Ct. Kings Co., Jack M. Battaglia, J., Aug. 12, 2005). This burden of proof is properly placed on a claimant health care provider because presumably it is in possession of the injured party's medical records.

"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 WL 2829826 (App. Term 2d & 11th Dists. Sept. 29, 2006). Assuming the insurer establishes a lack of medical necessity based upon an IME doctor's testimony, it is ultimately the claimant who must prove, by a preponderance of the evidence, that the services were medically necessary. Amato v. State Farm Ins. Co., 40 Misc.3d 129(A), 975 N.Y.S.2d 364 (Table), 2013 N.Y. Slip Op. 51113(U), 2013 WL 3497906 (App. Term 2d, 11th & 13th Dists. July 3, 2013), rev'g, 30 Misc.3d 238, 910 N.Y.S.2d 637 (Dist. Ct. Nassau Co. 2010) (district court held that IME cannot form basis for denying benefits unless post-IME records are reviewed); see also Dayan v. Allstate Ins. Co., 49 Misc.3d 151(A), 29 N.Y.S.3d 846 (Table), 2015 N.Y. Slip Op. 51751(U), 2015 WL 7900115 (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., 952 N.Y.S.2d 372, 374 n. (App. Term 2d, 11th & 13th Dists. 2012).

Dr. Brian Wolin, D.C., wrote the IME report relied upon by Respondent in asserting lack of medical necessity for further chiropractic treatment. Dr. Wolin's report is dated June 22, 2016, when he examined Assignor.

At the outset of his report, Dr. Wolin noted that Assignor was a driver of a vehicle who wore a seatbelt on April 13, 2016, when an accident occurred. She went to the ER at Kings County Hospital and was treated. She injured her neck, shoulders, mid back, and lower back. Thereafter Assignor underwent physical therapy, acupuncture, massage, and chiropractic. Dr. Wolin listed the various medical reports concerning Assignor's post-accident treatment which he reviewed.

Assignor complained of pain in the neck, right shoulder, mid back, and lower back, insofar as the spine is concerned, wrote Dr. Wolin. The latter observed that Assignor was able to walk well on tiptoes and heels, and did not walk with an antalgic gait. Examination of the cervical spine yielded no tenderness. There was no muscle spasm. There was complete range of motion: flexion 50/50 degrees, extension 60/60 degrees, rotation 80/80 degrees, and lateral flexion 45/45 degrees. Other provocative orthopedic tests were negative: Cervical Distraction, Soto-Hall, Foraminal Compression, and Jackson's Compression. The deep tendon reflexes of the biceps and triceps were 2+ and equal bilaterally. No muscle atrophy was noted of the upper extremities. There was no motor or sensory loss.

Examination of the thoracic spine revealed no tenderness. There was no paraspinal spasm. In the lumbar spine, there was mild tenderness to palpation of the

lumbar paraspinal muscles. There was no muscle spasm. There was complete range of motion: flexion 60/60 degrees, extension 25/25 degrees, rotation 30/30 degrees, and lateral bending 25/25 degrees. Other provocative orthopedic tests were negative: Straight Leg Raise, Nachlas, Fabere-Patrick, Ely's, and Kemp's. Minor's Sign was absent. Patellar and Achilles reflexes were 2+ and equal bilaterally. There were no motor or sensory deficits.

Dr. Wolin diagnosed resolved sprain/strain of the cervical, thoracic, and lumbar spines. As a chiropractor, he did not examine or diagnose other areas concerning which Assignor complained of pain. He opined, "There is no necessity for chiropractic care. It is my opinion that there is no necessity for chiropractic treatment or massage therapy."

I find that Dr. Wolin's IME report contained a factual basis and a medical rationale. It established a prima facie case for Respondent that chiropractic past its cutoff was not medically necessary. Per the cited case law the burden of proof shifted to Applicant to rebut the IME findings and affirmatively prove medical necessity.

Applicant argued that a July 19, 2016 chiropractic follow-up report rebutted the IEM report. Applicant's submission contains a report dated July 19, 2016. At the top of the first page it lists Applicant and its address. The report records normal sensation, normal upper extremity muscle strength, mildly reduced lower extremity muscle strength, muscle spasm, normal reflexes, some positive orthopedic test results, and quantified reduced ranges of motion. However, the script signature is illegible and not identified with a printed name. It does not indicate that the doctor is a chiropractor. Hence, I accord it no probative value.

There are other follow-up exam reports in the record. However, they are from medical doctors, physical therapists, or acupuncturists. They too would not be probative as to whether chiropractic was medically necessary.

In balancing the evidence from both parties, I find that from Respondent more probative and persuasive. I find that Applicant failed to meet its burden of proof. It was Respondent who proved lack of medical necessity for the subject chiropractic. I sustain the IME cutoff defense asserted by Respondent in its denials of claim. That defense overcomes Applicant's prima facie case of entitlement to No-Fault compensation.

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.

11/18/2017
(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:

17ccb256484f3c62fd6a4e6feead3c62

Electronically Signed

Your name: Aaron Maslow
Signed on: 11/18/2017