

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Muntaz Majeed MD  
(Applicant)

- and -

Geico Insurance Company  
(Respondent)

AAA Case No. 17-16-1052-0861  
Applicant's File No. MMMS-174  
Insurer's Claim File No. 0282384440101043  
NAIC No.

**ARBITRATION AWARD**

I, Phyllis Saxe, 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 (DD)

1. Hearing(s) held on 11/30/2017  
Declared closed by the arbitrator on 11/30/2017

Melissa Scotti, Esq. from Palumbo & Associates, PC participated in person for the Applicant

Justin Addison from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 5,554.23**, was AMENDED and permitted by the arbitrator at the oral hearing.

Amount in dispute was \$ 5,554.23 was amended down to \$4,349.74.

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

3. Summary of Issues in Dispute

The dispute before me arises from an automobile accident that occurred on August 8, 2015. Assignor (DD) then a 50-year-old driver of one of vehicles sustained injuries. The Assignor started on a course of conservative treatment, for pain to her neck lower back and shoulder.

Applicant, Muntaz Majeed, MD. provided physical therapy treatment to Assignor, and submitted the bills for services provided from November 15, 2015 through May 30, 2016 in the total amount, after amending down the amount, to \$4349.74.

The Respondent's raised multiple defenses to payment of these bills denying them all, based on an IME report of Dr. Sheth, ending orthopedic and physical therapy treatment as of 11/4/ 15, and then another IME by Dr. Kiernan ending orthopedic and physical therapy services as of 2/4/16.

The issues are whether the defenses including the two IME's denying treatment on lack of medical necessity should be sustained.

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

This award is based on my thorough review of the documentary evidence submitted by the parties to the American Arbitration Association and maintained in the MODRIA, electronic case filing system and oral arguments presented by both parties' representatives during the hearing.

In considering the medical necessity issue, I note that "[a]s part of its prima facie showing, the [patient or, as here, the provider, assignee] is not required to show that the contents of the statutory no-fault forms themselves are accurate or that the medical services documented therein were rendered or necessary. Stated another way, the [patient's assignee] is not required to establish the merits of the claim to meet its prima facie burden. (Viviane Etienne Med. Care, P.C. v Country-Wide Ins. Co., 114 A.D.3d 33, 45, aff'd 25 NY3d 498).

The NF-10 denial of claim form dated 4/19/16,

For DOS from 12/9/15 -3/11/16 Initially, Applicant's counsel argues that the denial is defective on its face in that it does not apprise Applicants of the basis of denial with any specificity. It is well settled that a no-fault insurer is bound by the "four corners of the denial" and "must "stand or fall upon the defense upon which it based its refusal to pay." Todaro v. Geico General Insurance Company, 46 A.D.3d 1086, 848 N.Y.S.2d 393 (3rd Dept. 2007). Moreover, a denial must "promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated." General Accident Insurance Company v. Cirucci, 46 N.Y.2d 862, 414 N.Y.S.2d 512 (1979).

I agree with applicant. This denial of claim form checks off Box 18, for fee schedule defense and stated OTHER and refers to multiple pages labeled explanation of benefits (EOB) to explain the codes used next to each date of service. Next to each of the thirty

dates of service in this bill, are 2 codes- 224 and FCC04. The Explanation of Benefits references four explanations for the denials.

The first reason for the denial of certain benefits (referred to various lines in the explanation of benefits ) NY-FSL for line 1 indicates that bills exceeds the permissible charges pursuant to the Workers Compensation Fee Schedule. The second reason for the denials is an explanation of benefits is coded at 224-fcc04 and stats that the charges were previously billed and reviewed.

The third reason for denial in the explanation of benefits is coded DF06 - and refers to Dr. Kiernan's IME report dated 1/28/16, which terminated orthopedic services as of 2/4/16.

The fourth reason for the denial is coded DP05 and refers to Dr. Kiernan's 1/28/16 IME report which terminated services on 2/14/16.

Respondent must stand on the four corners of the denial. These denials refer to two different codes DF06 and DP05 both which refer to this same IME report. two of the same IME reports, and refer to the same line numbers in the bills. I find this denial too confusing to support its validity.

While I understand that respondent used many different medical necessity verification processes, conducted over the 4 month period, applicant should be clearly apprised of the basis for the denials. Repeating Dr. Kiernan 'sIME as the basis for the denials and using two different codes for the same IME, and referring to the same line numbers is too confusing. It is a material defect in the denials and thus, I reject this denial of claim does not find that this denial contains a material defect.

Accordingly, I reject the denial dated 4/19/16 and award Applicant \$2,028.00 representing 30 DOS at \$67.60.

Dr. Sheth's IMe

The IME by Dr. Sheath is asserted as a basis for the denial for the bill for DOS of 12.21/15. He terminated services as of 11/13 /15.

If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary, the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. (See A.B. Medical Services, PLLC v. Geico Insurance Co., 2 Misc. 3d 26 [App Term, 2nd &

11th Jud Dists 2003]; Kings Medical Supply Inc. v. Country Wide Insurance Company, 783 N.Y.S. 2d at 448 & 452; Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc. 3d 128 [App Term, 2nd and 11<sup>th</sup> Jud Dists 2003]).

The IME conducted by Dr. Sheath failed indicated that the patient had recovered from her injuries. however, he concluded that the paiten should continue her home excercise program to facilitate her recovery.

In addition, Dr. Majeed's report dated 11/2- 15, contemporaneous in time to the IME, stated that unresolved injuries in the neck and lower back deficits in range of motion, and positive orthopedic test findings.

Upon careful consideration of the evidence presented in connection with Dr. Sheth's IME, I find that the respondent failed to meet the necessary burden of proof to sustain the denials based on Dr. Sheth's IME.

Accordingly, I find that Applicant is awarded \$185. 96 for DOS 12/21/15.

#### Dr. Kiernan's IME

The IME was conducted on January 28, 2016. Dr. Kiernan examined the patients range of motion, in all parts of the injured body and performed orthopedic tests that were all negative. Muscle strength was normal, no muscle spasms and no tenderness to touch. He therefore concluded that no further orthopedic treatment including physical therapy is medically necessary

There are monthly reports from Dr. Majeed in which he describes that the patient's pain level as worsening. He repeats the same range of motion results in his report and indicates no red flags, normal muscle strength, and reflexes. He does not indicate whether he used a goniometer, and I think that he should have indicated what instrumently he sued to arrive at the range of motion deficits. Aside from the range of motion deficits, the tests are normal. After 5 months of treatment he recommends no pain management of even an orthopedic referral.

Upon careful consideration of the respective evidence in these reports, I find Dr. Kiernan's report to be cogent and medically authoritative, to be more persuasive on the issue of continued treatment.

Accordingly, I deny all bills with dates of service after 2/4/16 except I awarded payment for dates of service until 3/11/16 when I rejected the denial to those services.

Applicant is awarded \$2,213.96 in full satsifaction of this calim

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
	<b>Muntaz Majeed Med Serv PLLC</b>	<b>11/20/15 - 05/30/16</b>	<b>\$5,554.23</b>	<b>\$4,349.74</b>	<b>Awarded: \$2,213.96</b>
<b>Total</b>			<b>\$5,554.23</b>		<b>Awarded: \$2,213.96</b>

- B. The insurer shall also compute and pay the applicant interest as set forth below. (The filing date for this case was 12/30/2016, which is a relevant date only to the extent set forth below.)

The insurer shall compute interest and pay the Applicant the amount of interest computed from the filing date as indicated above at the rate of 2% per month, simple, not compounded, calculated on a pro rata basis using a thirty-day month, and ending with the 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

The Respondent shall pay the Applicant an attorney's fee in accordance with 11 NYCRR 65-4.6(d) of 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon subject to a maximum fee of \$1,360.00.

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

12/27/2017  
(Dated)

Phyllis Saxe

#### **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:**  
36aec8e60c3b48450bb1827debea1e42

### **Electronically Signed**

Your name: Phyllis Saxe  
Signed on: 12/27/2017