

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Island Musculoskeletal Care, M.D., P.C.
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-17-1055-7147
Applicant's File No.	IMC-17-163147
Insurer's Claim File No.	0066219690101073
NAIC No.	35882

ARBITRATION AWARD

I, Evelina Miller, 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: DK

1. Hearing(s) held on 03/06/2018
Declared closed by the arbitrator on 03/06/2018

Naomi Jean-Philippe Esq from Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara, Wolf LLP participated in person for the Applicant

Elizabeth Henley Esq from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,839.39**, was NOT AMENDED at the oral hearing.
Stipulations WERE NOT made by the parties regarding the issues to be determined.
3. Summary of Issues in Dispute

Whether Applicant established entitlement to No-Fault compensation for MRI of the Cervical and Thoracic spine performed on Assignor

Whether Respondent made out a prima facie case of lack of medical necessity for said injections, and if so, whether Applicant rebutted it.

4. Findings, Conclusions, and Basis Therefor

Applicant was represented by Naomi Jean-Philippe Esq., who presented oral arguments and relied upon documentary submissions. Elizabeth Henley Esq., appeared on behalf of Respondent and presented oral arguments and relied upon documentary submissions. I have reviewed the submissions contained in MODRIA. These submissions are the record in this case.

The dispute arises from the underlying automobile accident of September 18, 2016, in which the Assignor (DK), a 51-year-old-female was involved. Thereafter patient sought private medical attention and was eventually evaluated by Dr. Gus Katsigiorgis D.O. Patient presented with complaints of pain in the neck, mid back and bilateral shoulders. Patient was recommended to undergo a course of conservative care. Eventually patient was recommended to undergo MRIs of the Cervical and Thoracic spine. The bills in dispute are for MRI of the Cervical spine performed on the patient on 9/27/16, and MRI of the Thoracic spine performed on the patient on 9/29/16.

I find that Applicant establishes its prima facie showing of entitlement to recover first-party no-fault benefits by submitting evidentiary proof that the prescribed statutory billing forms, setting forth the fact and amount of the loss sustained, had been mailed and received and that payment of no-fault benefits were overdue. See *Mary Immaculate Hospital v. Allstate Insurance Co.*, 5 A.D.3d 742, (2d Dept., 2004).

Applicant's proof is also in Respondent's denials, which acknowledged receipt of the bill. Since Applicant establishes its prima facie showing of entitlement to recover first-party no-fault benefits, the burden then shifts to the Respondent to demonstrate a lack of medical necessity for the items at issue. See, *Citywide Social Work & Psychological Services, PLLC v. Allstate Ins. Co.*, 8 Misc 3d 1025 A (2005).

On 11/1/16, Respondent issued a timely for date of service of 9/27/16 based on a peer review by Dr. Richard Semble M.D. performed on 10/26/16. Upon review of the medical records, Dr. Semble concluded that there was no medical necessity for the MRI of the Cervical spine at issue.

On 11/14/16, Respondent issued a timely for date of service of 9/29/16 based on a peer review by Dr. Richard Semble M.D. performed on 11/4/16. Upon review of the medical records, Dr. Semble concluded that there was no medical necessity for the MRI of the Thoracic spine at issue.

Medical Necessity:

A denial premised on a lack of medical necessity must be supported by competent evidence such as an independent medical examination, a peer review or other proof which sets forth a factual basis and a medical rationale for denying the claim. *Healing Hands Chiropractic, P.C., v. Nationwide Assur. Co.*, 5 Misc., 3d 975, 787 N.Y.S. 2d 645 (Civ.Ct., New York County, 2004); *King's Med. Supply Inc. v. Country Wide Ins. Co.*, 5Misc. 3d 767, 783 N.Y.S. 2d 448.

Once Respondent submits an IME report or peer review that has a sufficient factual basis and medical rationale, then the courts have routinely found that Respondent has

established its prima facie defense that the disputed medical service is medically unnecessary. *A Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co.*, 16 Misc.3d 131(A), 841 N.Y.S.2d 824 (Table, Text in WESTLAW), Unreported Disposition, 2007 WL 1989432, 2007 N.Y. Slip Op. 51342(U) (N.Y. Sup. App. Term Jul 03, 2007). See also, *Amaze Medical Supply Inc. v. Eagle Insurance Company*, 2003NY Slip Op 51701 (U), 2 Misc.3d. 128 (App. Term 2d & 11 Dist.-2003).

A conclusion set forth in a peer review may be insufficient if it fails to provide 1) specifics of the claim; 2) is conclusory; or 3) otherwise lacks a basis in the facts of the claim, *Amaze Medical Supply v. Allstate Ins. Co.*, 3 Misc3d 43 [App Term 2d Dept 2004].) To meet its burden of proving disputed services were not medically necessary, respondent's expert must demonstrate the disputed treatment was rendered in a manner inconsistent with generally accepted professional practice, which is the range of practice that the profession will follow in the diagnosis and treatment of the patient in light of the standards and values that define it. (See *CityWide Social Work & Psychological Services, P.L.L.C. v. Travelers Indemnity Co.*, 3 Misc3d 608 [Civ Ct Kings Co 2004].)

Peer Review by Dr. Richard Semble M.D. - Cervical Spine 9/27/16

On October 26, 2016, Dr. Richard Semble M.D. performed a Peer review to determine the medical necessity of the MRI of the Cervical Spine performed on the patient on 9/27/16.

Dr. Semble reviewed medical records of the Assignor. Based on the medical records provided, the medical history of the assignor as well as established medical guidelines Dr. Semble concluded that there was no medical justification for the MRI of the Cervical Spine performed on the Assignor on 9/27/16.

Dr. Semble states that the standard of care in this case was conservative care which the patient had not undergone prior to undergoing the MRI. He also states that the patient's clinical presentation did not warrant the MRI of the Cervical spine. The patient's clinical presentation was due to trauma which had occurred just 9 days prior to the MRI. He cites to medical authority to support his opinion.

Peer Review by Dr. Richard Semble M.D. - Thoracic Spine 9/29/16

On November 4, 2016, Dr. Richard Semble M.D. performed a Peer review to determine the medical necessity of the MRI of the Thoracic Spine performed on the patient on 9/29/16.

Dr. Semble reviewed medical records of the Assignor. Based on the medical records provided, the medical history of the assignor as well as established medical guidelines Dr. Semble concluded that there was no medical justification for the MRI of the Thoracic Spine performed on the Assignor on 9/29/16.

Dr. Semble states that the clinical presentation of the patient did not warrant the MRI. He cites to medical literature which states that the standard of care is 4-6 weeks of conservative care prior to consideration of an MRI in cases of radiculopathy and persistent pain, or progressively severe symptoms despite conservative care.

Once Respondent submits an IME report or peer review that has a sufficient factual basis and medical rationale, then the courts have routinely found that Respondent has established its prima facie defense that the disputed medical service is medically unnecessary. *A Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co.*, 16 Misc.3d 131(A), 841 N.Y.S.2d 824 (Table, Text in WESTLAW), Unreported Disposition, 2007 WL 1989432, 2007 N.Y. Slip Op. 51342(U) (N.Y. Sup. App. Term Jul 03, 2007). See also, *Amaze Medical Supply Inc. v. Eagle Insurance Company*, 2003NY Slip Op 51701 (U), 2 Misc.3d. 128 (App. Term 2d & 11 Dist.-2003).

In order for an applicant to prove that the disputed expense was medically necessary, it must meaningfully refer to, or rebut, the conclusions set forth in the peer review. *High Quality Medical, P.C. v. Mercury Ins. Co.*, 2010 N.Y. Slip Op. 50447(U) (App Term 2d, 11th & 13th Dists. Mar. 10, 2010); *Pan Chiropractic, P.C. v. Mercury Ins. Co.*, 24 Misc.3d 136(A), 2009 N.Y. Slip Op. 51495(U) (App Term 2d, 11th & 13th Dists. July 9, 2009).

Rebuttal by Applicant:

Applicant submits a rebuttal by Dr. Gus Katsigiorgis D.O. who is the treating provider in this case. He reviewed both peer reports by Dr. Semble and he disagreed with his opinion. Dr. Katsigiorgis cites to medical literature which states that MRI of the Cervical spine may be appropriate after a high impact motor vehicle accident, or when the patient presents with red flags. He states that the patient's clinical presentation made the MRI necessary.

Regarding the Thoracic Spine, Dr. Katsigiorgis states that the MRI of the Thoracic spine was not performed prematurely, 11 days post-accident. He cites to medical literature which states that the ultimate judgement regarding any procedure is up to the treating provider. Additionally, he cites to medical literature discussing lower back pain which states that the MRI may be recommended without time constraints for patients who endure "low velocity trauma (e.g. fall from height or struck by object.) He states that the patient's clinical presentation warranted the MRI of the Thoracic spine.

Conclusion

After careful consideration of both parties' submissions, as well as oral arguments presented at hearing, I find the following. Initially I find that Respondent was able to establish in establishing its prima facie defense that the services at issue were medically unnecessary. The crux of both peer reports by Dr. Semble is that the patient's clinical presentation did not warrant performance of the MRIs of the Cervical and Thoracic Spine. Additionally, Dr. Semble stated that both the MRIs were performed prematurely. The Cervical MRI was performed 9 days post-accident, and the MRI of the Thoracic Spine was performed 11 days post-accident. Dr. Katsigiorgis submits a rebuttal in

response to Respondent's peers. He cites to medical literature which states that it is up to the treating provider to determine the course of treatment. Furthermore, he states that the MRI of the Cervical spine may be performed in cases of high impact collision. The MRI of the Thoracic spine may be performed in cases of low velocity trauma. Upon my review of all the evidence discussed above I agree with Respondent. Both the MRIs in this case were performed less than 2 weeks post-accident. It is up to the treating provider to determine the course of treatment as noted by Applicant. However, there are guidelines that the medical community has established that medical professionals have to follow when treating their patients. Here the standard of care is 4-6 weeks of conservative care prior to consideration of Imaging studies. Additionally, the clinical presentation of the patient did not reveal any red flags indicated by both doctors as necessary to warrant the MRIs so early in treatment. Based on the above, I find that Applicant failed to rebut the conclusions of the Peer doctor.

Accordingly, Applicant's claim for reimbursement is denied.

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 Nassau

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

04/10/2018

(Dated)

Evelina Miller

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:
436c9009bfff8903815d21c63366c6fb

Electronically Signed

Your name: Evelina Miller
Signed on: 04/10/2018