

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Citimed Services, PA
(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-17-1059-0323
Applicant's File No.	FL17-22501
Insurer's Claim File No.	0472827050101034
NAIC No.	22055

ARBITRATION AWARD

I, Bernadette Connor, 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

1. Hearing(s) held on 03/29/2018
Declared closed by the arbitrator on 03/29/2018

Merav Dekel, Esq. from Field Law Group, P.C. participated in person for the Applicant

Tal Sloan, Esq. from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,575.00**, was AMENDED and permitted by the arbitrator at the oral hearing.

Applicant amended the amount claimed to \$544.76, in compliance with the fee schedule.

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

3. Summary of Issues in Dispute

Whether Applicant is entitled to reimbursement for medical services provided to the Assignor herein as a result of injuries sustained in a motor vehicle accident that occurred on June 25, 2016.

4. Findings, Conclusions, and Basis Therefor

I have carefully reviewed the submissions contained in the Modria ADR Center maintained by the American Arbitration Association. I have also considered the oral arguments of the parties presented at the hearing of this matter.

An arbitrator "shall be the judge of the relevance and the materiality of the evidence offered, strict conformity to the rules of evidence shall not be necessary. The arbitrator may question or examine any witness or party and independently raise any issue that arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department regulations." 11 N.Y.C.R.R. 65-45 (o) (1). Additionally, as the trier of the facts and the law, an Arbitrator is authorized to review and take judicial notice of any rule, law, medical document or periodical or any other document which may impact and aid in making a decision, as long as it conforms to the Insurance laws and the New York State Insurance Department Regulations. *Matter of Medical Society v. Serio*, 100 NY2d 854, 768 NYS2d 423 (2003).

Applicant seeks reimbursement for anesthesia in connection with bilateral medial branch block injections of the thoracic spine and the lumbar spine provided to the Assignor, a 31-year-old male, who sustained injuries to the neck and back in a motor vehicle accident on June 25, 2016. The date of service at issue is January 8, 2017. Respondent denied payment based on a report dated February 28, 2017, from Jason R. Cohen, M.D.

Dr. Cohen reviewed the Assignor's medical records and concluded that the services provided on January 8, 2017, were not medically necessary. Dr. Cohen indicated that the medical records provided for his review did not reveal any facet joint pathology throughout the lumbar spine and the thoracic spine. He also indicated that there was no documentation of focal tenderness overlying the thoracic facet joints at the levels blocked on January 8, 2017.

In response to Dr. Cohen's report, David Abbatematteo, M.D., issued a rebuttal report dated December 12, 2017. Dr. Abbatematteo disagreed with Dr. Cohen's conclusion that the bilateral medial branch blocks of the lumbar spine and the thoracic spine were not medically necessary. Dr. Abbatematteo noted that an MRI study of the lumbar spine performed on July 30, 2016, revealed broad-based disc herniation at L3-4, L4-5, and L5-S1, resulting in mild compression and impingement upon the thecal sac with narrowing of the neural foramina bilaterally. According to Dr. Abbatematteo, the records documented further evidence indicative of lumbar facet syndrome and thoracic facet syndrome: severe difficulty in prolonged sitting, standing, walking, lifting, and carrying heavy objects; difficulty sitting and standing for more than 5 minutes; pain aggravated by movement. Dr. Abbatematteo indicated that findings upon examination revealed tenderness on the paralumbar and thoraco-spine paraspinals, and lumbar extensors. There was also painful muscle spasm of the bilateral paravertebral musculature, tenderness, and pain at palpation of the multiple trigger points in the lumbosacral and thoracic areas, decreased range of motion of the lumbar spine in

flexion, extension, left and right lateral flexion, left and right rotation. Orthopedic tests, including straight leg raising test, Kemp's test, Fabere-Patrick test, and Yeoman's test, were positive.

Under Section 5102 of the New York Insurance Law, No-Fault first party benefits are reimbursable for all medically necessary expenses due to personal injuries arising out of the use or operation of a motor vehicle. Applicant establishes a prima facie entitlement to judgment as a matter of law by proof that it submitted a claim, setting forth the fact and amount of the loss sustained, and that the payment of No-Fault benefits was overdue. See Insurance Law Section 5106a; *Mary Immaculate Hosp. v. Allstate Ins. Co.*, 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]; *Damadian MRI in Canarsie, P.C. v. General Assurance Company*, 2006 NY Slip Op 51048U, 2006 NYS Misc. Lexis 1363 (Decided June 2, 2006, Appellate Term, 2d Department); *Amaze Medical Supply, Inc. v. Eagle Insurance Company*, 2 Misc. 3rd 128, 784 N.Y.S. 2d 918 (2003).

Once Applicant establishes a prima facie case of medical necessity, the burden then shifts to Respondent. Respondent must then produce a peer review or other competent medical evidence which sets forth a clear factual basis and medical rationale for denying the claim. *Healing Hands Chiropractic P.C. v. National Assurance Co.*, 5 Misc. 3d 975; *Citywide Social Work, et. al. v. Travelers Indemnity Co.*, 3 Misc. 3d 608. Further, a report relied upon by an insurer to defend its denial of No-Fault benefits must demonstrate that the services rendered were not in agreement with generally accepted medical/professional practice. *Jacob Nir, M.D. Assignee of Josaphat Etienne v. Allstate Insurance Co.*, 796 N.Y.S.2 857. "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." *Citywide Social Work & Psy. Serv. P.L.L.C. v. Travelers Indemnity Co.*, 3 Misc. 3d. 608, 777 N.Y.S. 2d 241, 2004 NY Slip Op 20034 NY Slip Op 24034 [Civ. Ct. Kings County 2004].

After carefully reviewing the evidence presented, I find in favor of Applicant. Dr. Abbatematteo's rebuttal report persuasively and credibly demonstrated that the bilateral medial branch block injections to the lumbar spine and the thoracic spine provided to the Assignor in this matter was reasonable and medically necessary. See, *Exclusive Med. Supply, Inc. v Mercury Ins. Group*, 2009 52273 (U) (Appellant Term 2d Dept., Nov. 5, 2009); *Delta Diagnostic Radiology, P.C. v. Progressive Casualty Ins. Co.*, 2008 Slip Op 52450 (U), 21 Misc. 3d 142 (A) (App Term 2d Dept., 2008). *Khodadadi Radiology v. New York Central*, 16 Misc. 3d 131 (A) (2007). When an insurer's consultant sets forth a sufficient factual basis and medical rationale to support the consultant's opinion that the disputed services were not medically necessary, the insurer has successfully rebutted Applicant's prima facie case of medical necessity. The burden then shifts back to Applicant to counter the insurer's consultant's report and demonstrate the necessity of the services at issue.

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
	Citi Med Services, PA	01/08/17 - 01/08/17	\$1,575.00	\$544.76	Awarded: \$544.76
Total			\$1,575.00		Awarded: \$544.76

- B. The insurer shall also compute and pay the applicant interest set forth below. 04/10/2017 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Respondent issued timely denials for Applicant's claim. Therefore, pursuant to *LMK Psychological Services*, 12 N.Y.3d 217, 879 N.Y.S.2d 14 (2009), interest shall begin to accrue as of the date the claim is received by the American Arbitration Association until payment is made. The interest shall be two percent per month, simple, not compounded, on a pro rata basis using a 30 day month.

C. Attorney's Fees

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

With respect to the claim for which compensation was awarded, Respondent shall pay Applicant an attorney's fee in accordance with 11 NYCRR 65-4.6 (e). Since the within arbitration request was filed on or after April 5, 2002, if the benefits and interest awarded thereon are equal to or less than Respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b).

- 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 New York

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

04/29/2018
(Dated)

Bernadette Connor

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:
b84d10b6e1d6d27a9ee46afac29d15e9

Electronically Signed

Your name: Bernadette Connor
Signed on: 04/29/2018