

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Tim Canty M.D. PLLC  
(Applicant)

- and -

Geico Insurance Company  
(Respondent)

AAA Case No.	17-16-1042-4559
Applicant's File No.	A07501
Insurer's Claim File No.	0497324540101023
NAIC No.	35882

**ARBITRATION AWARD**

I, Preeti Priya, 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 [GVF]

1. Hearing(s) held on 08/29/2018  
Declared closed by the arbitrator on 08/29/2018

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

Diana Gonzalez, Esq., from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,941.62**, 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 physical therapy services and diagnostic testing provided to Assignor;

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

Whether Applicant submitted proof of claim to Respondent within 45 days after the services were rendered.

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

Applicant was represented by Andrew Bruskin, Esq., who presented oral arguments and relied upon documentary submissions. Diana Gonzalez, Esq., appearing on behalf of Respondent, presented oral arguments and relied upon documentary submissions. I have reviewed the submissions contained in the American Arbitration Association's ADR Center. These submissions are the record in this case.

The disputes arise from the underlying automobile accident of December 7, 2015 in which the Assignor, a 42-year-old female, was a driver. Assignor sought private medical attention and was evaluated by Brett Saal, DC, on December 14, 2015. Assignor received conservative care including physical therapy. Assignor also underwent diagnostic tests. Applicant submitted the claims for physical therapy sessions and diagnostic tests for dates of service between April 26 and July 20, 2016 to Respondent; Respondent denied the claims.

*April 26, 2016*

For this date of service, Respondent denied payment based on an untimely submission. Respondent's explanation of review attached to the NF-10 states "DF08\_FCC04 Denial is made due to non-compliance with the Mandatory Personal Injury Protection Endorsement which stipulates that written proof of claim must be submitted as soon as reasonably practicable, but in the case of health service expenses no later than 45 days after the date services are rendered or 45 days after the date written notice was given to the Company, whichever is later, unless the eligible injured person submits written proof that it was impossible to comply with such time limitation due to specific circumstances beyond such person's control."

"Written proof of claim was provided more than 45 days after the services were rendered" and Respondent relies upon 11 N.Y.C.R.R. § 65-1.1 which provides:

"Conditions Proof of claim, Medical In the case of a claim for health service expenses, the eligible injured person or that person's assignee or legal representative shall submit written proof of claim to the Company, including full particulars of the nature and extent of the injuries and treatment received and contemplate, as soon as reasonably practicable, but in no event later than 45 days after the date services are rendered. The foregoing time limitations for the submission of proof of claim shall apply unless the eligible injured person or that person's legal representative submits written proof providing clear and reasonable justification for the failure to comply with such time limitation."

If a denial of claim premised on the health care provider's failure to submit its claim form to the insurer within 45 days informed the provider that it could excuse the delay if the Applicant/ provider provided written justification for the delay, and the provider does not establish that it provided the insurer with the written justification for the untimely submission, the insurer should be granted judgment. AR Medical

Rehabilitation, P.C. v. MVAIC, 27 Misc.3d 135(A), 910 N.Y.S.2d 760 (Table), 2010 N.Y. Slip Op. 50828(U), 2010 WL 1910908 (App. Term 2d, 11th & 13th Dists. May 10, 2010).

An insurer may not invoke the 45-day rule to deny a claim where it fails in its denial form to apprise the claimant that late notice will be excused where it can provide reasonable justification for the failure to give timely notice. SZ Medical P.C. v. Country-Wide Ins. Co., 12 Misc.3d 52, 817 N.Y.S.2d 851 (App. Term 2d & 11th Dists. 2006).

The denial language does not meet the criteria as stated in AR Medical Rehabilitation, P.C. v. MVAIC and SZ Medical P.C. v. Country-Wide Ins. Co., supra.

Further as held by Arbitrator Aaron Maslow in OBB Acupuncture PC v Geico Ins. Co. AAA 17-16-1033-8546 (January 18, 2017): "There is also case law discussing the specific verbiage used to convey the advisory mandated by the regulations. A denial of claim form complies with 11NYCRR 65-3.3(e) when it adequately advises the claimant that late submission of the claim will be excused if the claimant provides a reasonable justification for the failure to timely submit the claim. E.g., Prestige Medical & Surgical Supply, Inc. v. Chubb Indemnity Ins. Co., 26 Misc.3d 145(A), 2010 N.Y. Slip Op. 50449(U), (App. Term 2d, 11th & 13th Dists. Mar. 10, 2010). Stating, "[U]nless the eligible injured person submits written proof providing clear and reasonable justification for failure to comply with such time limitation," and reasonable justification not proven, for proof of claim" does not substantially satisfy the requirement that a denial of a claim for late notice of claim advise the applicant that "late notice will be excused where the applicant can provide reasonable justification of the failure to give timely notice"; the language used presents a fait accompli conclusion that reasonable justification was not proven. Medical Select, P.C. v. Allstate Ins. Co., 42 Misc.3d 851, 979 N.Y.S.2d 472 (Dist. Ct. Nassau Co. 2013)." In the case at bar, the language set forth in Respondent's denial of claim form stated that the eligible injured person had to submit "written proof that it was impossible to comply with such time limitation due to specific circumstances beyond such person's control." This language was actually set forth in the No-Fault Regulations which were in effect prior to those adopted in 2001 which took effect on Apr. 5, 2002. The regulations which took effect on Apr. 5, 2002 lessened the standard by which a claimant could prove an excuse for late proof of claim and late notice of claim: late notice will be excused where the applicant can provide reasonable justification of the failure to give timely notice."

Based on the foregoing, Applicant's claim of \$67.60 is granted.

*July 20, 2016*

After reviewing the records, I find that Applicant established its prima facie case of entitlement to No-Fault compensation. See Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). The burden now shifts to the Respondent to demonstrate lack of medical necessity. See Alvarez v. Prospect Hosp., 68 N.Y.S.2d 320, 501 N.E.2d 572, 508 N.Y.S.2d [1986]; A.B. Medical Services v. Geico Ins. Co., 2 Misc 3d 26 [App Term 2d and 11th Jud Dists, 2003]).

On August 12, 2016, Sammy Dean, MD, performed a peer review at Respondent's request regarding the medical necessity of the electrodiagnostic tests performed on July 20, 2016. Dr. Dean reviewed numerous medical records including: diagnostic test results; progress notes; MRI test results; examination reports and progress notes. He then outlined the treatment of the Assignor.

The No-Fault carrier may rebut the inference of medical necessity by providing proof that the claimed healthcare benefits were not medically necessary. A. Khodadadi Radiology, P.C. v. New York Central Mutual Fire Ins Co., 16 Misc 3d 131(A), 841 N.Y.S.2d 824, 2007 N.Y. Slip Op 51342(U) (App Term, 2nd Dept - 2007); Delta Diagnostic Radiology, P.C. v. Progressive Casualty Ins. Co., 21 Misc 3d 142(A), 2008 NY Slip Op 52450(U) (App Term, 2nd Dept - 2008); Delta Diagnostic Radiology, P.C. v. Integon Natl. Ins. Co., 2009 NY Slip Op 51502(U) (App Term, 2nd Dept - 2009). Where the No-Fault carrier's proof consists of a peer review report, that report must be predicated upon a sufficient factual basis and medical rationale. AJS Chiropractic, P.C. v. Mercury Ins. Co., 2009 NY Slip Op 50208(U), 22 Misc 3d 133(A) (App Term, 2nd Dept - 2009).

Dr. Dean opined "In the case of the claimant under review the diagnosis of radiculopathy was considered and, based on physical exam findings and history, an EMG is not justified." He found "The claimant has noted positive root tension testing and neurological complaints in the upper extremities. There were no abnormal neurological examination findings available. The claimant has a prior MRI of the cervical spine. An MRI provides a clear view of disc changes and nerve pathology, and aids in specializing treatment to a claimant's particular diagnosis and condition." He concluded with "There is no clear indication of the need for electrodiagnostic testing, considering the prior MRI and noted neurologically normal examination."

"[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), 806 N.Y.S.2d 443 (Table), 2005 WL 1936346 at 3 (Civ. Ct. Kings Co., Jack M. Battaglia, J., Aug. 12, 2005). In A.B Med Servs., P.L.L.C. v. State Farm Mut Auto Ins Co., 7 Misc. 3d 822, 795 N.Y.S 2d 843(App Term, 2ndDept - 2005) citing Baumann v. Long Is. R.R., 110 A.D.2d 739, 741 487 N.Y.S.2d 833 (AppDiv., 2nd Dept - 1985) the Court held that a plaintiff continues to bear the "burden of persuasion" and, if the carrier has satisfied the burden of coming forward, a "plaintiff Must rebut it or succumb". Also see); Crotona Hgts. Med., P.C. v. Geico Ins. Co., 25 Misc 3d142(A), 2009 NY Slip Op 52466(U) (AppTerm, 2nd Dept - 2009); AJS Chiropractic, P.C. v.Travelers Inc. Co., 25 Misc 3d 140(A),2009 NY Slip Op 52446(U) (App Term, 2nd Dept -2009).

Applicant submitted a Rebuttal by Tim Canty, MD in support of the tests and in response to the Peer Review report. Dr. Canty disagreed with Dr. Dean and stated, "The standard of care cited by Dr. Dean was met in this case." He stated "the patient's diagnosis of radiculopathy was not clinically obvious." He noted "For instance, during

the many months when the patient saw Marlon Soriano, the patient had numbness and tingling over the left arm and hand....."

Respondent submitted an Addendum by Dr. Dean in which he reiterated his conclusions. He stated "After a thorough review of the additional records provided to me, including the response to peer review dated 8/13/2018 by Tim Canty MD, PLLC, it remains my opinion the services under review are not medically necessary. There is limited new information refuting my prior rationale for denial." He noted "The claimant under review was seen on 6/15/16, with noted radicular complaints and a suspected diagnosis of cervical radiculitis. Said examination indicated a previous plan of care include cervical epidural steroid injection, postponed due to improvement in the claimant's condition with conservative modalities, such as physical therapy and pain medication. Considering the claimant's improving status and a plan of care for an interventional procedure for a diagnosis of cervical radiculopathy, there remains"

I am not persuaded by Dr. Canty. I find Dr. Dean discusses in detail why the tests were not medically necessary. Applicant has not rebutted Respondent's defense and has not sustained Applicant's burden of proof by a preponderance of credible evidence regarding medical necessity.

*May 23 to June 29, 2016*

Since Respondent's denials were timely, it was within its rights to assert that further treatment was medically unnecessary. See Liberty Queens Medical, P.C. v. Liberty Mutual Insurance Co., 2002 NY Slip Op 40420(U), 2002 WL 31108069 (App. Term 2d & 11th Dists. June 27, 2002); Country-Wide Insurance Co. v. Zabloski, 257 A.D.2d 506, 684 N.Y.S.2d 229 (1st Dept. 1999).

The claims were denied based on an independent medical examination conducted on May 11, 2016, by Shariar Sotudeh, MD, at Respondent's request. Based on the examination and the report, no-fault benefits were terminated on May 18, 2016. Various medical records including evaluation reports, progress notes and diagnostic test results were reviewed. Dr. Sotudeh then outlined the Assignor's treatment and medical history as it related to the accident. Assignor did not need any further orthopedic care.

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 NY Slip Op 51863(U), 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., 22 Misc.3d 133(A), 2009 NY Slip Op 50208(U), 2009 WL 323421 (App. Term 2d & 11th Dist. Feb. 9, 2009), 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 NY Slip Op 50568(U), 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 NY Slip Op. 51282(U), 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.

Applicant did not submit a rebuttal directly addressing the IME examination and report. Applicant submitted progress notes and reports contemporaneous to the IME but these records do not refute the IME. I find Dr. Sotudeh conducted a thorough examination. I am not persuaded by Applicant's submission nor by Assignor's medical records. Applicant has not rebutted Respondent's defense and has not sustained Applicant's burden of proof by a preponderance of credible evidence regarding the medical necessity of the services provided to Applicant. Applicant's claim is denied.

Based on the foregoing, Applicant is awarded \$67.60.

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	Status
	Tim Canty M.D. PLLC	04/26/16 - 07/20/16	\$1,941.62	Awarded: \$67.60
Total			\$1,941.62	Awarded: \$67.60

- B. The insurer shall also compute and pay the applicant interest set forth below. 08/23/2016 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant's award shall bear interest at a rate of two percent per month, calculated on a pro rata basis using a 30-day month from the date payment became overdue to the date of the payment of the award pursuant to 11 NYCRR 65-3.9 (a). The end date for the calculation of the period of interest shall be the date of payment of the claim. General Construction Law § 20 ("The day from which any specified period of time is reckoned shall be excluded in making the reckoning.")

C. Attorney's Fees

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

Respondent shall pay Applicant a separate attorney's fee, in accordance with 11 NYCRR 65-4.6(d). Since the within arbitration request was filed on or after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with 11 NYCRR 65-4.6(d).

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

09/10/2018  
(Dated)

Preeti Priya

**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:**  
562fb3981eacb3d72f0e3c12875d5109

### **Electronically Signed**

Your name: Preeti Priya  
Signed on: 09/10/2018