American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Orlin & Cohen Orthopedic Assoc. (Applicant)	AAA Case No.	17-18-1090-3572
	Applicant's File No.	MurphyDon
- and -	Insurer's Claim File No.	0166291400101064
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Jennifer Jacques, 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: EIP

1. Hearing(s) held on 01/25/2019
   Declared closed by the arbitrator on 01/25/2019

   Karen Wagner from Dash Law Firm, P.C. participated in person for the Applicant

   Ann Troxler from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 879.73**, 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 or not Respondent properly denied Applicant's claim for medical services based upon a lack of medical necessity pursuant to a peer review?

4. Findings, Conclusions, and Basis Therefor

The EIP is a 57-year-old female, injured as a pedestrian by a motor vehicle on 08/30/17. Applicant seeks $879.73 for MRI's performed on 09/28/17. Respondent denied Applicant's claim based upon lack of medical necessity according to the peer review of Richard D. Semble, M.D.

I have completely reviewed all timely submitted documents contained in the ADR Center record maintained by the American Arbitration Association and considered all oral arguments. No additional documents were submitted by either party at hearing. No witnesses testified at hearing.

ANALYSIS

Applicant has established its prima facie entitlement to reimbursement for no fault benefits as a matter of law based upon the submission of a properly completed claim form setting forth the amount of the loss sustained and that payment is overdue. Mary Immaculate Hospital v. Allstate Insurance Company, 5 AD 3d 742, (2 Dept. 2004).

The burden now shifts to Respondent to establish a lack of medical necessity with competent medical evidence, which sets forth a clear factual basis (specifics of the claim) and medical rationale for denying the claim. Citywide Social Work and Psych Services, PLLC v. Allstate, 8 Misc. 3d 1025A (2005); Healing Hands Chiropractic v. Nationwide Assurance Co., 5 Misc. 3d 975 (2004). Respondent must offer sufficient and credible medical evidence that addresses the standards in the applicable medical community for the services and treatment in issue; explains when such services and treatment would be medically appropriate, preferably with understandable objective criteria; and why it was not medically necessary in the instance at issue.

The insurer must establish a factual basis and medical rationale for its asserted lack of medical necessity, which is supported by evidence of the generally accepted medical/professional practices. Beal Medea Products Inc. v. Geico, 27 Misc. 3d 1218 (A), 910 NYS 2d 760 (Civ. Ct. Kings County 2010).

Respondent timely denied the instant claim based upon a peer review by Richard A. Semble, M.D dated 10/26/17. The Peer report herein sets forth a factual basis and medical rationale for the services at issue. AJS Chiropractic, PC v. Mercury Ins. Co, 22 Misc. 3d 133 (A), 880 NYS 2d 871 (App. Term 2d & 11th Jud Dist. 2009). Dr. Semble reviewed sufficient medical records and he noted that the EIP presented on 09/05/2017 with complaints of pain in the neck and right shoulder. Cervical Spine Examination: Inspection of the cervical spine was as follows: no scars, no erythema, no ecchymosis, no masses and no rashes. As part of the treatment plan, the claimant was referred for an x-ray of cervical spine.

Dr. Semble noted that an MRI of the cervical spine was done on 09/28/2017, revealing the impression of broad-based left paracentral disc herniation and bony ridging encroaching upon the cord and left exiting CS nerve root at C4-C5, multilevel degenerative disc disease, straightening of the cervical lordosis without acute fracture or cord impingement, cystic nodule in the right thyroid gland measuring approximately 1.9 cm not adequately evaluated on the current exam, and correlation with physical exam and ultrasound is recommended.

Dr. Semble also noted that the EIP has no history of prior surgery or injury to the cervical spine that would necessitate an MRI scan for further assessment. The physical examination did not reveal any radicular pain, weakness or reflex abnormalities. Dr. Semble also highlighted that there were no neurologic impairments of the upper extremities. Dr. Semble concluded that the EIP should have been treated with an adequate course of active conservative care including physical therapy, and if her symptoms persisted then an MRI scan would have been reasonable and medically necessary.

Respondent established a reasonable factual basis and medical rationale with its expert opinion as to the medical necessity for the disputed treatment. Applicant must now meaningfully refer to or rebut the conclusions set forth in the peer review. Yklik, Inc v. Geico Ins Co, 2010 NY Slip Op 51336(u) (App Term 2nd, 11th and 13th Jud Dist. 7/22/10). In the absence of such a rebuttal, the claim may be denied.

In support of its position, Applicant submitted a Rebuttal by Jeffrey Mait, M.D., wherein he indicated that in this case, the EIP complained of constant, aching and radiating pain in the neck along with weakness in the right arm. The EIP further indicated that the pain causes sleep disturbance and stiffness. Dr. Mait noted that the examination of the cervical spine revealed tenderness, and muscle spasm. Based on the patient's complaints and finding upon examination, Dr. Mait's diagnostic impression was acute strain of neck muscle.

Dr. Mait further opined that the MRI study of the cervical spine revealed broad based left paracentral disc herniation and bony ridging encroaching upon the cord and left exiting C5 nerve root at C4-C5. Based on the aforementioned, Dr. Mait concluded that the cervical spine MRI study performed in this case medically necessary and justified.

Dr. Semble submitted an addendum wherein he stated that there was no indication of neurological deficit either static or progressive.

Decision

I have reviewed the medical reports dated 9/05/17 wherein the EIP complained of pain on a scale of 3 out of 0-10. I have also reviewed the peer report and the Rebuttal and I find that the Applicant was unable to sufficiently to overcome the findings of Dr. Semble as to lack of medical necessity. It is the Applicant's burden, ultimately, to establish the medical necessity of the services at issue. 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). I find the evidence submitted by Respondent more credible on the necessity, or lack thereof, of further treatment for the EIP's injuries.

Based upon the reasons forth above, I find in favor of the Respondent. Based on the foregoing, Applicant's claim is denied in its entirety.

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

01/30/2019
(Dated)

Jennifer Jacques

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:
830d2c15270d106fa98ec72ebca0306e

Electronically Signed

Your name: Jennifer Jacques
Signed on: 01/30/2019