

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

DRD Medical P.C.  
(Applicant)

- and -

Allstate Insurance Company  
(Respondent)

AAA Case No. 17-17-1075-8811

Applicant's File No. 181-A-2672  
ARB

Insurer's Claim File No. 0436118640

NAIC No. 19232

**ARBITRATION AWARD**

I, Nicholas Tafuri, 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 (MC)

1. Hearing(s) held on 03/21/2019  
Declared closed by the arbitrator on 03/21/2019

Michael Nathan, Esq. from Lewin & Baglio LLP participated in person for the  
**Applicant**

Hamilton Driggs, Esq. from Allstate Insurance Company participated in person for the  
**Respondent**

2. The amount claimed in the Arbitration Request, **\$ 92.98**, 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

EIP, MC, is a 70-year-old female, who was a passenger in a motor vehicle involved in an accident on November 14, 2016. Following the accident, EIP sought medical treatment. Health services were provided by Applicant on 6/19/17.

Applicant's claim for reimbursement of the health service provided, an office visit, was denied by Respondent based on an IME by Dr. Roger Antoine, held on 5/17/17.

The issue presented is whether Applicant is entitled to no-fault reimbursement for health services denied based on an IME?

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the ADR Center Record as of the date of the hearing and this Award is based upon my review of the Record and the arguments made by the representatives of the parties at the Hearing. Pursuant to 11 NYCRR 65-4 (Regulation 68-D), §65-4.5 (o) (1), an Arbitrator shall be the judge of the relevance and materiality of the evidence offered, and strict conformity to legal rules of evidence shall not be necessary. The Arbitrator may question any witness or party, and independently raise any issue that the Arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations. The case was decided on the submissions of the Parties as contained in the ADR Center Record maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses.

EIP, MC, is a 70-year-old female, who was a passenger in a motor vehicle involved in an accident on November 14, 2016. Following the accident, EIP sought medical treatment. Health services were provided by Applicant on 6/19/17.

Applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained, and by submitting evidentiary proof that the prescribed statutory billing forms [setting forth the fact and the 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 Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find Applicant establishes a prima facie case. The burden then shifts to the Respondent to prove that the bills in question were properly denied.

Applicant's claim for reimbursement of the health service provided, an office visit, was denied by Respondent based on an IME by Dr. Roger Antoine, held on 5/17/17.

## MEDICAL NECESSITY

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment. Kingsborough Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D. 3d 13 (2d Dep't. 2009). See also Channel Chiropractic PC v. Country Wide Ins. Co., 38 AD 3d. 294 (1st Dep't. 2007). An insurance carrier must at a minimum establish a detailed factual basis and a sufficient medical rationale for asserting lack of medical necessity. See Delta Diagnostic Radiology PC v. Progressive Casualty Ins. Co., 21 Misc. 3d. (142A) (App. Term 2d Dep't. 2008).

An IME doctor must establish a factual basis and medical rationale for his asserted lack of medical necessity for future health care services. E.g., Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), (App. Term 2d & 11th Dists. Sept. 3, 2008); Carle Place Chiropractic v. New York Central Mut. Fire Ins. Co., 19 Misc.3d 1139(A), (Dist. Ct., Nassau Co., Andrew M. Engle, J., May 29, 2008).

Where an IME report provides a factual basis and medical rationale for an opinion that services were not medically necessary, and the claimant fails to present any evidence to refute that showing, the claim should be denied, AJS Chiropractic, P.C. v. Mercury Ins. Co., 22 Misc.3d 133(A), (App. Term 2d & 11th Dist. Feb. 9, 2002), as the ultimate burden of proof on the issue of medical necessity lies with the claimant. See Insurance Law § 5102; Wagner v. Baird, 208 A.D.2d 1087 (3d Dept. 1994).

Dr. Antoine's IME on 5/17/17, resulted in the termination of orthopedic care and related claims benefits effective 6/15/17. Dr. Antoine notes that he previously examined EIP on 3/22/17, and this IME is a re-evaluation. Dr. Antoine reports EIP's present complaints of pain in her neck and left rib. Upon examination, Dr. Antoine found slight restrictions in ranges of motion in EIP's lumbar spine and right shoulder. Ranges of motion of the cervical spine, left shoulder, elbows, wrists, hands, hips, knees, feet and ankles was normal. All orthopedic testing of EIP's multiple body parts were negative. The Foraminal Compression test and the Straight Leg Raising test were negative. In addition, Dr. Antoine found that deep tendon reflexes, muscle strength and sensation in the upper and lower extremities were normal. Based upon his examination, Dr. Antoine concluded that no further orthopedic treatment was medically necessary. With respect to the

decreased range of motion finding, Dr. Antoine notes EIP, a 71-year old at the time of the exam, with degenerative condition unrelated to the subject accident.

I find the results of this examination presented a medical rationale as to why further benefits were terminated. Based upon the foregoing, Respondent has set forth a cogent medical rationale in support of its defense. Since Respondent has factually demonstrated the services rendered were not medically necessary, the burden shifts to Applicant who bears the ultimate burden of persuasion.

For Applicant to prove that the disputed treatment was medically necessary, it must demonstrate that "the treatment, procedure, or service (was) ordered by a qualified physician...based on an objectively reasonable belief that it will assist in the patient's diagnosis and treatment and cannot be reasonably dispensed with". Nir v. Progressive Insurance, NYLJ, April 14, 2005, p.19, col. 1 (Civil Ct Kings County, J. Nadelson). Moreover, "(s)uch treatment, procedure, or service must be warranted by the circumstances as verified by a preponderance of credible and reliable evidence, and must be reasonable in light of the subjective and objective evidence of the patient's complaints." *Id.*

To counter the IME review findings and conclusions, Applicant relies on a submitted post-IME cutoff follow up examination dated May 19, 2017. The exam by Dr. David Dynof notes EIP with continuing complaints of pain in the neck and rib area. The cervical and lumbar spine exam reveals restrictions in ranges of motion, tenderness and muscle spasm. Spurling's test, distraction test, straight leg raise test and Yeoman's test are positive. Right shoulder exam revealed a positive Hawkins and abduction test. Right cervical trigger point injections are performed. Based on the evaluation, Dr. Dynof recommends continued physical therapy and pain management treatment.

The conflicting medical expert opinions adduced by the parties sufficed to raise an issue as to the medical necessity of the treatment underlying the provider's first-party no-fault claim. See Advanced Orthopedics, PLLC v. New York Central Mutual Fire Insurance Company, 42 Misc.3d 150 (A), 2014 N.Y. Slip Op. 50418(U) (App. Term 2nd, 11th and 13th Jud. Dists.

2014); Pomona Medical Diagnostics, P.C. v. Praetorian Insurance Company, 42 Misc.3d 126(A), 2013 N.Y. Slip Op. 52131(U) (App Term 1st Dept. 2013).

After careful consideration of both parties' medical evidence, I find that the Applicant has refuted the IME examiner's determination that no further orthopedic and related benefits were necessary. Based upon the positive findings documented in the post-IME cutoff re-evaluation from Dr. Dynof dated 5/19/17 (2 days post IME), I find, as a matter of fact, that the services provided to the Assignor after the termination date imposed by the Respondent was medically necessary.

Accordingly, based upon the foregoing, I find in favor of the Applicant in the amount of \$92.98.

This decision is in full disposition of all claims for no-fault benefits presently before this arbitrator.

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
	DRD Medical P.C.	06/19/17 - 06/19/17	\$92.98	Awarded: \$92.98
Total			\$92.98	Awarded: \$92.98

- B. The insurer shall also compute and pay the applicant interest set forth below. 10/09/2017 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Respondent shall compute and pay to Applicant the amount of interest from the filing date of the Request for Arbitration, at a rate of 2% per month, simple interest (i.e. not compounded) using a 30-day month and ending with the date of payment of the award, subject to the provisions of 11 NYCRR 65-3.9(c).

C. Attorney's Fees

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

For cases filed prior to February 4, 2015, the attorney's fee shall be calculated as follows: 20% of the amount of first party benefits awarded herein, plus interest thereon, subject to a minimum fee of \$60 and a maximum of \$850. 11 NYCRR 65-4.

For cases filed on or after February 4, 2015, the attorney's fee shall be calculated as follows: 20% of the amount of first-party benefits awarded, plus interest thereon, subject to no minimum fee, and a maximum fee of \$1,360.00. 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 Nassau

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

03/24/2019  
(Dated)

Nicholas Tafuri

### **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:**  
c353062183af5d2f2c2d982f7575b1ec

### **Electronically Signed**

Your name: Nicholas Tafuri  
Signed on: 03/24/2019