

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Stand Up MRI OF Queens
(Applicant)

- and -

Maya Assurance Company
(Respondent)

AAA Case No. 17-18-1100-0555

Applicant's File No. 18-002292

Insurer's Claim File No. 170728-01

NAIC No. 36030

ARBITRATION AWARD

I, Teresa Girolamo, Esq., 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: H.G.

1. Hearing(s) held on 06/19/2019
Declared closed by the arbitrator on 06/19/2019

Robert Bott, Esq. from Super & Licatesi P.C. participated in person for the Applicant

Christina Gutierrez, Esq. from De Martini & Yi, LLP participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,571.80**, was NOT AMENDED at the oral hearing.
Stipulations WERE made by the parties regarding the issues to be determined.

It was stipulated and agreed by and between the parties at the time of the hearing that Applicant has established its *prima facie* case and that Respondent's denial is timely.

3. Summary of Issues in Dispute

Whether Respondent's Denial/ Explanation of Medical Bill Payment regarding the lumbar spine MRI is defective is defective.

Whether Applicant's unpaid bills in the amount of 1,571.80 for the Lumbar MRI and a Cervical MRI denied by Respondent for lack of medical necessity based upon a Peer review by Gary J. Kelman, M.D. dated 1/29/18 should have been paid.

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the Electronic Case Folder as of the date of the hearing.

Both Applicant and Respondent each submitted evidence in support of their contentions. This decision is based on my review of that file, as well as the arguments of the parties at the hearing.

According to Applicant's AR-1 there are two bills; the first billed in the amount of \$659.80 for the cervical spine MRI and the second \$912.00 for the lumbar spine MRI each performed on 12/31/17. As such, there are two denials. The denial for the lumbar spine MRI was issued on 2/5/18 and states that the denial is based upon a peer report on 1/29/18 by Harry Goldmark, M.D. The denial for the cervical spine MRI was also issued on 2/5/18 which states that it was denied based upon a peer report by Gary J. Kelman, M.D.

In this case, Respondent acknowledges that there was only one peer report by Gary J. Kelman, M.D. and argues that the language on the denial regarding the lumbar spine MRI is an "immaterial defect". Applicant argues that providing the wrong name of a peer reviewer, goes to the foundation for the basis of the denial and is "significant".

Pursuant to the 4th Amendment to 11 NYCRR 65-3.8 (h) same reads as follows:

With respect to a denial of claim (NYS Form N-F 10), an insurer's non-substantive technical or immaterial defect or omission shall not affect the validity of a denial of claim. This subdivision shall apply to medical services rendered, and to lost earnings and other reasonable and necessary expenses incurred, on or after April 1, 2013.

Having considered the arguments of the parties, and having reviewed the evidence herein, I find that the defect in Respondents Explanation of Medical Bill Payment to be a substantive material defect and as such affects the validity of the denial of

claim. Therefore, I find the Denial defective wherein Applicant's claim is granted in the amount of \$912.00 for the MRI of the lumbar spine. The next issue is one of medical necessity regarding the cervical spine MRI.

With respect to the question of medical necessity, Respondent has the burden to rebut the claim with proof that the health care services were not medically necessary or with some other viable defense (See *Amaze Med. Supply v. Eagle Ins. Co.*, 2 Misc. 3rd 128[A] 2003).

With respect to lack of medical necessity is an affirmative defense that is the Respondent's burden to prove. See, *Alliance Medical Office, P.C. v. Allstate*, 196 Misc.2d 268, 269, 764 N.Y.S.2d 341, 342 (Civil Ct., Kings Cty. 2003); *Choicenet Chiropractic^{na} P.C. v. Allstate*, 2003 WL 1904296, 2003 N.Y. Slip Op. 50672U (App.Term 2 Dept. 2003). "At a minimum, [Respondent] must establish a factual basis and medical rationale for the lack of medical necessity of [Applicant's] services. *Nir v. Allstate*, 7 Misc.3d 544, 546-47, 796 N.Y.S.2d 857, 860 (Civil Court, Kings Cty. 2005).

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 N.Y. Slip Op. 51282 (U) at 3, 2005, WL 193646 (Civ. Ct. Kings Co. Jack M. Battaglia, J. August 12, 2005). The burden is on the insurer to show lack of medical necessity. See, *Expo Med. Supplies, Inc. v. Clarendon Ins. Co.*, 2006 N.Y. Slip Op. 50892U, 12 Misc. 3d 1154A, 2006 N.Y. Misc. LEXIS 1169 [Civ. Ct., Kings Co., 2006]. See, also, *A.R. Med. Art., P.C. v. State Farm Mut. Auto Ins. Co.*, 2006 N.Y. Slip Op. 50260U, 11 Misc. 3d 1057A, 815 NYS2d 493, 2006 N.Y. Misc. LEXIS 348 [Civ. Ct., Kings Co., 2006]; *Citywide Social Work & Psy. Serv. v. Travelers Indem. Co.*, 3 Misc. 3d 608, 777 NYS2d 241 [Civ. Ct, Kings Co., 2004]; *Elm Medical P.C. v. American Home Assurance Co.*, 2003 N.Y. Slip Op. 51357U, 2003 N.Y. Misc. LEXIS 1337 [Civ. Ct., Kings Co., 2003];

A treatment or service is medically necessary if it is "appropriate, suitable, proper and conducive to the end sought by the professional health service in consultation with the patient. It means more than merely convenient or useful treatment or services, but treatment or services that are reasonable in light of the patient's injury, subjective and objective evidence of the patient's complaints of pain, and the goals of evaluating and treating the patient." *Fifth Avenue Pain Control Center v. Allstate*, 196 Misc. 2d 801, 807-808 (Civ. Ct. Queens Cty. 2003). Medically necessary treatment or services must be "consistent with the patient's condition, circumstances and best interest of the patient with regard to the type of treatment or services rendered, the amount of treatment or services rendered, and the duration of the treatment or services rendered." *Id.*

Medical services are compensable where they serve a valid medical purpose. *Sunrise Medical Imaging PC v. Lumbermans Mutual* 2001 N.Y. Slip Op. 4009.

"A peer review report's medical rationale is insufficient if it is unsupported by or controverted by evidence of medical standards." *Id.* Similarly, "[a] peer review report's factual basis may be insufficient if it fails to provide specifics of the claim, is conclusory, or otherwise lacks a basis in the facts of the claim." *Id.*, citing, *Amazon Medical Supply v. Allstate*, 3 Misc.3d 43, 779 N.Y.S.2d 715 (App Term 2d and 11 Jud Dists 2004).

In order for Respondent to meet its burden of establishing the lack of medical necessity, a peer review should (1) set forth applicable accepted medical standards relevant to the services at issue; and (2) comment on whether the Applicant had followed or deviated from those standards in providing the disputed services. This does not necessarily require that the peer review quote or cite medical literature. The *Nir* decision clearly contemplates that a peer may cite "medical authority, standard, or generally accepted practice as a medical rationale for his findings". *Nir*, 7 Misc.3d at 548.

Only if Respondent can establish a *prima facie* defense does the burden of proof shift to Applicant to rebut the defense. See, *A. Khodadadi Radiology PC v. NY Central Mutual Fire Ins. Co.*, 2007 NY Slip Op 51342(U). In general, Applicant's "rebuttal" need not be in the form of an affidavit or other statement specifically created in response to the peer review; Applicant may rely on the existing medical records and reports already in evidence to counter the peer's arguments.

Respondent relies upon a peer report by Gary J. Kelman, M.D. in support of its affirmative defense of lack of medical necessity.

On 8/2/17 H.G. was involved in a motor vehicle accident. At that time H.G. was a then 62-year-old male. As a result of said accident H.G. sustained injuries and began a course of care which included but not limited to acupuncture treatment; chiropractic care; physical therapy; MRIs, including the cervical spine MRI performed on 12/31/17 which is now in dispute.

Respondent denied the cervical spine MRI based upon a peer report of Gary J. Kelman, M.D. According to Gary J. Kelman, M.D. the initial evaluation by Dr. Kim; who referred H.G. for the cervical spine MRI, was on 11/29/17 and in reviewing this evaluation "there is no evidence that the claimant's physiological and neurological status was deteriorating despite a course of conservative treatment." Referencing literature, one of the indications for an MRI of the cervical spine would be "significant neurological findings and failure to respond to conservative therapy despite compliance with the therapeutic regimen." As such it was the opinion of Gary J. Kelman, M.D. that the cervical spine MRI was not medically necessary.

Having considered the arguments of the parties and having reviewed the evidence herein, I find that Respondent has established its affirmative defense of lack of medical necessity and that Applicant is unable to rebut same. As such, the claim for the reimbursement regarding the Cervical Spine MRI 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 applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Total	Status
	Stand Up MRI OF Queens	12/31/17 - 12/31/17	\$659.80	\$ 912.00	Denied
	Stand Up MRI OF Queens	12/31/17 - 12/31/17	\$912.00	\$ 912.00	Awarded: \$912.00
Total			\$1,571.80	Awarded: \$912.00	

- B. The insurer shall also compute and pay the applicant interest set forth below. 07/06/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest is owing from filing date of 7/6/18 to date of payment.

C. Attorney's Fees

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

The Respondent shall also pay the applicant an attorney's fee, in accordance with No Fault Regulations.

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

07/19/2019
(Dated)

Teresa Girolamo, Esq.

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:
5da7721bca5be816f3921596f8c47d7d

Electronically Signed

Your name: Teresa Girolamo, Esq.
Signed on: 07/19/2019