American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Sebastian Medical PC (Applicant)	AAA Case No.	17-17-1062-3235
	Applicant's File No.	1973598
- and -	Insurer's Claim File No.	0371895160101014
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Kathleen Sweeney, 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: IP

1. Hearing(s) held on 06/18/2019
   Declared closed by the arbitrator on 06/18/2019

   Scott Fisher from Israel, Israel & Purdy, LLP (Great Neck) participated in person for the Applicant

   Odisinia Okeya from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 236.83**, 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 the denial based on an IME can be sustained?

   This arbitration arises out of medical treatment for the IP, a 42 year old female, related to injuries sustained in a motor vehicle accident that occurred on 1/13/11. Applicant seeks reimbursement for an office visit. Respondent has denied the bill in question based on an IME by Dr. Denton with an effective date of 6/1/11. This was a re-exam by Dr. Denton who originally saw the IP in March, 2011 and allowed further treatment.

4. Findings, Conclusions, and Basis Therefor

Applicant has established its prima facie case with proof that it submitted a proper claim, setting forth the fact and the amount charged for the rendered services and that payment of no-fault benefits was overdue (see Insurance Law § 5106 a; Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]; Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784 N.Y.S. 2d 918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]).

It is Applicant's prima facie obligation to establish its entitlement to payment for each service for which reimbursement is sought. It is well settled that a health care provider establishes its prima facie entitlement to payment as a matter of law by proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue (see Insurance Law § 5106 a; Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD 3d 742, 774 N.Y.S. 2d 564 [2004]; Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784 N.Y.S. 2d 918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]).

Upon proof of a prima facie case by the Applicant, the burden shifts to the insurer to prove that the services were not medically necessary. A.B. Medical Services, PLLC v. Lumbermens Mutual Casualty Company, 4 Misc.3d 86, 2004 N.Y. Slip Op. 24194 (App.Term 2nd and 11th Jud. Dists. 2004); Kings Medical Supply, Inc. v. Country-Wide Insurance Company, 5 Misc.3d 767, 2004 N.Y. Slip Op. 24394 (N.Y. Civ. Ct. Kings Co. 2004); Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc.3d 128(A), 2003 N.Y. Slip Op. 51701(U) (App Term 2nd and 11th Jud. Dists. 2003). If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary, the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. (See A.B. Medical Services, PLLC v. Geico Insurance Co., 2 Misc. 3d 26 [App Term, 2nd & 11th Jud Dists 2003]; Kings Medical Supply Inc. v. Country Wide Insurance Company, 783 N.Y.S. 2d at 448 & 452; Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc. 3d 128 [App Term, 2nd and 11 Jud Dists 2003]).

According to the IME report offered by Dr. Benton, he reviewed the medical records of the IP and performed an examination. The records reveal that the IP was able to get on and off the examining table without assistance and had a normal gait and had driven herself to the exam. She wore no assistive device. The opinion of the Dr. was that there was no need for any further orthopedic treatment, including physical therapy. His opinion was that the injuries were resolved and there was no need for further treatment.

The case law states that if the insurer presents sufficient evidence establishing a lack of medical necessity, then the burden shifts back to the Applicant to present its own evidence of medical necessity. See: West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc3d 131A (2006). Applicant has relied on the medical records submitted which do not convince me that continued treatment was necessary. Frankly, the records

are void of anything significant and note that the IP is back driving a bus as she was before the accident. They show the IP able to do exercises at home.

Comparing the relevant evidence presented by both parties against each other I find I am persuaded by the Respondent. I find that Applicant did not prove medical necessity by a preponderance of the credible evidence. Rather, Respondent proved lack of medical necessity. Accordingly, after reviewing the entire record and after careful consideration of the parties' oral arguments, I sustain the defense asserted in the denials. Applicant's claim is denied. This decision is in full disposition of all claims for No-fault benefits presently before this Arbitrator.

Accordingly, the denial is sustained. 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 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, Kathleen Sweeney, 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)

Kathleen Sweeney

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:
6b261d5d8b1283228a76862a424d8761

Electronically Signed

Your name: Kathleen Sweeney
Signed on: 07/19/2019