American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

New York Spine Specialists (Applicant)	AAA Case No.	17-18-1089-6400
	Applicant's File No.	2081934
- and -	Insurer's Claim File No.	67520-02
	NAIC No.	24309
Hereford Insurance Company (Respondent)		

ARBITRATION AWARD

I, Stacey Charkey, 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

1. Hearing(s) held on 07/16/2019
   Declared closed by the arbitrator on 07/16/2019

   Justin Skaferowsky, Esq. from Israel, Israel & Purdy, LLP (Great Neck) participated in person for the Applicant

   Michael Poropat, Esq. from Law Offices of Rubin & Nazarian participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 92.94**, 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 is entitled to reimbursement for an office visit purportedly performed in connection with injuries sustained as the result of a motor vehicle accident occurring on 5/19/17 in which the assignor, a 57 year old male claimed multiple injuries. Respondent issued a denial for services based upon an IME performed by its consultant, Dr. Jay Eneman.

4. Findings, Conclusions, and Basis Therefor

Applicant seeks further reimbursement, along with interest and counsel fees, under the No-Fault Regulations, for an office visit performed in connection with injuries allegedly sustained by Assignor in a motor vehicle accident. The visits were denied based upon the results of a physical examination (IME) performed at the behest of the Respondent by its consultant. All denials were timely issued. This decision is based upon the written submissions of counsel for the respective parties as well as oral argument. A hearing was conducted. I have reviewed the documents contained in the Electronic Case Folder as of the date of the Hearing.

Assignor, a then 57 year old man, was involved in an automobile accident on 5/19/17 after which he apparently began a treatment regimen for complaints of neck pain, left elbow pain and right wrist pain. A wrist fracture suffered during the accident. Assignor was examined by Applicant on 12/4/17 for complaints of neck pain. Assignor's complaints included neck pain, wrist pain and elbow pain.

Assignor was examined on 10/10/17 at Respondent's request by Dr. Jay Eneman, MD who recommended that further orthopedic treatment cease as not necessary. The consultant health care provider opined that Assignor was not suffering from any disability for which any further therapy was required. Based upon his recommendations, all orthopedic therapies including physical therapy were effectively cut-off. It is noted that Dr. Eneman did not perform a thorough examination of the cervical spine and concentrated on assignor's chief complaint with regard to the wrist.

Respondent insured the motor vehicle involved in the automobile accident.

Under New York's Comprehensive Motor Vehicle Insurance Reparation Act (the "No-Fault Law"), New York Ins. Law §§ 5101 et seq., Respondent was obligated to reimburse the injured party (or its assignee) for all "reasonable and necessary expenses" and "medical expenses" arising from the use and operation of the insured vehicle.

A claimant "(makes) a prima facie showing of entitlement to judgment as matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and that payment of no-fault

benefits were overdue." Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D. 3rd 742, 774 N.Y.S 2d 564 (2nd Dept. 2004). See also: Amaze Medical Supply v. Eagle Insurance, in which the Appellate Term notes that "a properly completed claim form, which suffices on its face to establish 'the particulars of the nature and

extent of the injuries and [health benefits] received and contemplated,' and the 'proof of the fact and amount of loss sustained' is all that is needed at the claim stage to establish the health benefits medical necessity." (Citations within quoted language omitted). 3 Misc. 3rd 43, 779 N.Y.S. 2d 715).

After a prima facie case has been presented, the claim must generally be paid or denied within 30 days, or it is "overdue," commencing the accrual of interest and attorney fees. See, N.Y. Ins. Law § 5106[a] (McKinney 2000); 11 NYCRR § 65-3.8(a)(1), Presbyterian Hospital v. Maryland Cas. Co., 90 N.Y.2d 274, 660 N.Y.S.2d 536 (1997). The 30-day period in which to deny a claim may be extended, inter alia, by a timely and proper demand for further verification of a claim. 11 NYCRR § 65-3.5(b). In addition to being timely, a denial of claim

must contain all of the information required by the prescribed denial form, and must "promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated," See, Nyack Hospital v. State Farm Mutual Automobile Insurance Co., 11 A.D. 3rd 664, 784 N.Y.S.2D 236, citing, inter alia, General Acc. Ins. Group . Cirucci, 46 N.Y.2d 862. 864, 387 N.E.2d 233, 414 N.Y.S.2d 512.

Assignor was examined on 10/10/17 at Respondent's request by Dr. Jay Eneman, who recommended that further treatment cease as not necessary. The consultant health care provider opined that Assignor was not suffering from any disability for which any further therapy was required. Based upon his recommendations, all physical therapies were effectively cut-off. The at issue office visit was denied based upon Dr. Eneman's IME report.

In a no-fault arbitration, Applicant must prove that the treatment rendered is causally related to the accident, that it was reasonable and that it was medically necessary. See, Insurance Law Sections 5102(a)(1) and (b); 11 NYCRR Section 65.12(e); 11 NYCRR Sections 65.15(g)(6), (m)(1), and (o)(vi) and; 11 NYCRR Section 65.17(b)(5)(xiv). In a no-fault arbitration,

Applicant bears the burden of proof. It has both the duty of going forward with the evidence and the burden

of persuasion as to each element of its claim. Opinion Letter, No-Fault Burden of Proof, Office of General Counsel, State Insurance Department (January 11, 2000). Separate and apart from any other issue herein, Applicant, however minimally, must establish a prima facie case regardless of the proof proffered by Respondent. In this matter it was incumbent on Applicant to establish the medical necessity of the treatment.

In order to prevail, Applicant must meet the statutory requisite and make out a prima facie case of entitlement to benefits. Applicant must therefore show "sufficient" evidence to be deemed reimbursable under the No-Fault Law. What constitutes "sufficient" evidence in each case is a question of fact to be determined by the trier of fact in each individual case.

As noted, Applicant establishes "a prima facie showing of their entitlement to judgment as matter of law by submitting evidentiary proof that the prescr ibed 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." Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). At bar, Applicant has submitted evidentiary proof sufficient to establish its prima facie burden.

Once Applicant has established a prima facie case the burden is on the insurer to prove that the medical treatment was medically unnecessary. See, Citywide Social Work & Psychological Services, PLLC a/a/o Gloria Zhune v. Allstate Ins. Co., 8 Misc.3d 1025A, 806 N.Y.S.2d 444 (App. Term 1st Dept. 2005); .A.B. Medical Services, PLLC v. Geico Ins. Co., 2 Misc 3d 26, 773 N.Y.S.2d 773 (App Term 2nd & 11th Jud Dist 2003).

Lack of medical necessity is a valid defense to an action to recover No-Fault benefits, Countrywide Ins. Co. v. 563 Grand Med., P.C., 50 A.D.3d 313 (1st Dept. 2008); A.B. Med. Servs., PLLC v. Liberty Mut. Ins. Co., 39 A.D.3d 779 (2d Dept. 2007), if raised in a denial that is (1) timely, Presbyterian Hosp. in the City of New York v. Maryland Casualty Ins. Co., 226 A.D.2d 613 (2nd Dept. 1996); Central Gen. Hosp. v. Chubb Group of

Ins. Co., 90 N.Y.2d 195 (1997), (2) includes the information called for in the prescribed denial of claim form, 11 NYCRR § 65-3.4 (c) (11); Nyack Hosp. v. Metropolitan Prop. & Cas. Ins. Co., 16 A.D.3d 564 (2d Dept. 2005); Nyack Hosp. v. State Farm Mut. Auto. Ins. Co., 2004 WL 2394038, 2004 NY Slip Op 07663 (2d Dept. Oct. 25, 2004); Summit psychological, P.C. v. General Assur. Co., 9 Misc.3d 8, (App Term 9th & 10th Jud Dists., 2005); Shtarkman v. Allstate Ins. Co., 8 Misc.3d 129(A), 2005 NY Slip Op 51028(U) (App Term 2d & 11th Jud Dists.), and (3) "promptly apprise(s) the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is

predicated", General Accident Ins. Group v. Cirucci, 46 N.Y.2d 862, 864, 414 N.Y.S.2d 512, 387 N.E.2d 223 (1979); New York University Hosp. Rusk Ins. v. Hartford Acc. & Indem. Co., 32 A.D.3d 458, 2006 NY Slip Op 06223 (2d Dept. 2006).

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 2009 NY Slip Op 00351 (App Div 2d Dept., Jan. 20, 2009); Channel Chiropractic, P.C. v. Country- Wide Ins. Co., 2007 Slip Op 01973, 38 A.D.3d 294 (1st Dept. 2007); Bronx Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co., 2007 NY Slip Op 27427, 17 Misc.3d 97 (App Term 1st Dept., 2007), such as by a qualified expert performing an independent medical examination, conducting a peer review of the injured person's treatment, or reconstructing the accident. Id.

An insurance carrier must, at a minimum, establish a detailed factual basis and a

sufficient medical rationale for its asserted lack of medical necessity. Vladimir Zlatnick, M.D., P.C. v. Travelers Indem. Co., 2006 NY Slip Op 50963(U) (App Term 1st Dept., 2006); Delta Diagnostic Radiology, P.C. v. Progressive Casualty Ins. Co., 2008 Slip Op 52450(U), 21 Misc.3d 142(A) (App Term 2d Dept., 2008).

An insurance carrier may utilize an independent medical examination (IME) to determine whether an eligible injured person is entitled to further care and treatment or other first-party benefits. See Rowe v. Wahnow, 26 Misc.3d 8, 11-12 (App Term, 1st Dept 2009, McKeon, P.J., dissenting).

"An IME is a snapshot of the injured party's medical condition as of the date" it is

conducted. Amato v. State Farm Ins. Co., 2010 NY Slip Op. 20431 (Dist. Ct. Nassau Co., Fred J. Hirsh, J., Oct. 13, 2010). An IME report must set forth a sufficient factual basis and medical rationale for the conclusion that further services are not medically necessary. See Ying E. Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), 2008 N.Y. Slip Op. 51863(U) (App Term 2d &11th Dists. Sept. 3, 2008).

The determination that an eligible injured person no longer needs treatment is generally based upon an examiner's findings that result in the conclusion that: (1) the patient has fully recovered from the injuries; (2) the patient has made as full a recovery as is possible taking into account the nature and extent of the injuries, the patient's age, pre-existing conditions or other factors; and/or (3) additional treatment or testing will not provide any medical benefit to the patient. Amato v. State Farm Ins. Co., 2010 NY Slip Op. 20431 (Dist. Ct. Nassau Co., Fred J. Hirsh, J., Oct. 13, 2010).

Given that the IME examiner, Dr. Eneman, also reviewed some of assignor's medical records, noted no tenderness, no muscle spasm, no motor or sensory deficits, negative orthopedic testing, normal reflexes, no gait abnormalities, and full range of motion; and concluded, inasmuch as there was no "objective evidence" of injury, that no further treatment was necessary, I find that the IME sets forth an adequate factual basis and medical rationale for the rejection of the post-IME claim, and, thus, is sufficient to rebut the presumption of medical necessity attached to it. See East Coast Acupuncture Servs., P.C. v. American Tr. Ins. Co., 2007 NY Slip Op 50213(U) (App. Term 1st Dept., Feb. 8, 2007); Vladimir Zlatnick, M.D., P.C. v. Travelers Ins. Indemnity Co., 12 Misc. 3d 128A (App. Term 1st Dept. 2006).

When, as here, an insurer interposes a timely denial of claim that sets forth a sufficiently detailed actual basis and adequate medical rationale for a claim's rejection, the presumption of medical necessity attached to the applicant's properly completed claim is rebutted and the burden shifts back to the claimant to refute the IME and prove the necessity of the disputed services. Id. See, e.g., CPT Med. Servs., P.C. v. New York Cent. Mut. Fire Ins. Co., 2007 NY Slip Op 27526,

18 Misc.3d 87 (App. Term 1st Dept.); Eden Med., P.C. v. Progressive Cas. Ins. Co., 2008 NY Slip Op 51098(U), 19 Misc.3d 143(A) (App Term 2d & 11th Jud Dists., 2008); Bath Med. Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 2008 NY Slip Op 50347(U) (App. Term 2d Dept., Feb. 26, 2008) (since the provider failed to rebut peer review's showing of a lack of medical necessity, defendant was entitled to dismissal of complaint); Be Well Med. Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 2008 NY Slip Op 50346(U)(App. Term 2d Dept., Feb. 21,

2008) (inasmuch as the provider offered no medical evidence to rebut the insurer's peer review, insurer should have been granted summary judgment); A. Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co., 2007 NY Slip Op 51342(U) (App Term 2d Dept.); West Tremont Med. Diagnostic, P.C. v. Geico Ins. Co., 2006 NY Slip Op 51871 (U) (App Term 2d Dept.); S&M Supp. Inc. v. Peerless Ins. Co., 2004 WL 2979217, 2004 NY Slip Op 51683 (U) (App Term, 2nd & 11th Jud Dists 2004); Amaze Medical Supply v. Eagle Ins. Co., 2 Misc.3d 128(A), 2003 NY

Slip Op 51701(U) (App. Term 2d Dept., Dec. 24, 2003); Damadian MRI In Elmhurst v. Liberty Mut. Ins. Co., 2003 NY Slip Op 51700(U) (App. Term 2d Dept., Dec. 24, 2003) ("a provider's proof of a properly-completed claim…shift(s) the burden to the insurer who…may rebut the inference by proof…establishing that the health benefits were not medically necessary", which, "(i)f not refuted by the no-fault benefits claimant, such proof may entitle the insurer to summary judgment").

While this Arbitrator does not strictly require a "rebuttal" to an IME, in order for an applicant to prove that the disputed expense was medically necessary, it must submit documentation that meaningfully refers to, or rebuts, the conclusions set forth in the IME report. Eastern Star Acupuncture, P.C. v. Mercury Ins. Co., 2010 NY Slip Op. 50380(U) (App. Term 2d, 11th & 13th Dists. Mar. 8, 2010).

A letter of medical necessity sworn to by a provider who had examined assignor, along with other medical documentation, may be sufficient to rebut the peer review and establish the medical necessity of the services rendered. See Quality Psychological Servs., P.C. v. Mercury Ins. Group, 2010 NY Slip Op 50601(U) (App Term 2d Dept., April 2, 2010). See also Vinings Spinal Diagnostic, P.C. v. Geico Gen. Ins. Co., 2010 NY Slip Op

51897(U) (App Term 2d Dept., Nov. 8, 2010) (an affidavit from a chiropractor "meaningfully referred to" the peer and

"sufficiently rebutted the conclusions set forth therein"). Applicant has submitted treatment notes outlining Assignor's clinical condition at or about the time of the IME demonstrating the need for further treatment. These treatment notes support Applicant's claim that continued treatment was medically necessary and sufficiently rebut the findings of Dr. Eneman. Indeed, it is the quality of the proof that must be weighed and balanced, not merely which party has the last word.

As to the post IME treatment for which reimbursement is now sought, Assignor was examined at Respondent's behest by Dr. Eneman who recommended that therapy cease as not necessary. Upon examination Dr. Eneman concluded that Assignor exhibited no deficits for which further therapy was required. In response to the IME report, Applicant has submitted treatment notes for the time period inclusive of the date of the IME, wherein Assignor continued to make complaints with respect to the cervical spine and exhibited clinical deficits referable to the underlying accident. Dr. Eneman did not adequately address Assignor's complaints of neck pain.

Dr. Eneman's examination and findings are in direct contradiction to the findings by Applicant's physicians. Applicant contends that the treatment was medically necessary in that it was beneficial. The Respondent contends otherwise. The Arbitrator is thus placed in the position of determining which of these opinions, (both of which on the surface appear credible and cogent), should be accorded the most weight.

Applicant was apparently confronted with certain subjective complaints as well as objective clinical findings and opined that further evaluation and treatment was medically necessary. A treating physician cannot merely discount and disregard her patient's subjective complaints as unfounded and irrational. Since there is such a divergence of medical opinions as to the necessity of the disputed therapy, I feel bound to defer to the opinions of Assignor's treating physicians rather than to the opinions of Respondent's IME consultant who was not personally responsible for Assignor's care and treatment.

I find Applicant's assessment to be credible and convincing. Based upon my careful review of all the evidence within the Record herein, including Assignor's subjective complaints which cannot be completely discounted when providing cautious health care, I find that Applicant has sustained its burden insofar as proving by a preponderance of the evidence, its case for the treatment for which it now seeks reimbursement.

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**
	New York Spine Specialists LLP	**02/05/18 - 02/05/18**	**$92.94**	**$ 92.94**	**Awarded: $92.94**
Total			**$92.94**	**Awarded: $92.94**	

B. The insurer shall also compute and pay the applicant interest set forth below. 03/20/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Where a claim is timely denied, interest shall begin to accrue as of the date the adjudication is commenced by the claimant, to wit: the date the application document was received by the American Arbitration Association, unless arbitration is commenced within 30 days as of the date the denial is received by the claimant. 11 NYCRR 65-3.9c. LMK Psychological Services P.C. v. State Farm Mut. Auto Ins. Co., 12 NY3d 217, 879 NYS2d 14 (2009). The end date for the calculation of the period of interest shall be the date of payment of the claim. In calculation the interest, the date of accrual shall be excluded from the calculation. Accordingly, at bar, unless specifically noted in the body of this award, the date the application document was received by AAA, shall be utilized as the date of accrual for the purpose of calculating interest. Where applicable, if noted within the body of this award, said date of accrual of interest shall be controlling.

C. Attorney's Fees

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

After calculating the sum total of the first-party benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicants an attorney's fee equal to 20 percent of that sum total, as provided for in 11 NYCRR 65-4.6 (as existing on the filing date of this arbitration), subject to a maximum fee of $1,360.00.

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 Queens

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

08/06/2019
(Dated)

Stacey Charkey

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:
1c976e76da46bad6f01648a6738fa1ac

Electronically Signed

Your name: Stacey Charkey
Signed on: 08/06/2019