American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

New York Spine Specialists (Applicant)	AAA Case No.	17-18-1097-6971
	Applicant's File No.	2121683
- and -	Insurer's Claim File No.	0541246850101013
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Henry Sawits, 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: the patient.

1. Hearing(s) held on 08/27/2019
   Declared closed by the arbitrator on 08/27/2019

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

   Frank Randazzo from Geico 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

   The issue in this arbitration is whether the services rendered to the patient were medically necessary?

4. Findings, Conclusions, and Basis Therefor

   I have reviewed the documents contained in the Electronic Case Folder 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.

This arbitration arises out of treatment of a forty-one-year old male for injuries sustained in a motor vehicle accident occurring on August 22, 2016. Applicant seeks reimbursement, in the amount of $92.98, for an office consultation with the patient on May 9, 2018.

Respondent issued a timely denial denying reimbursement based on a termination of further no-fault benefits effective February 25, 2018. The termination of benefits was based on the findings and opinions set forth in the report of an Independent Medical Examination of the patient conducted by Suman Brahmbhatt, M.D. on February 6, 2018 on behalf of the Respondent.

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]).*

It is *Respondent's* obligation to object to *any deficiencies* in Applicant's submissions by either formally objecting to any error or omission or seeking additional verification. Since Respondent failed to timely object to the completeness of the forms submitted by Applicant or seek verification of same as required by *11 NYCRR 65-3.5,* Respondent waived any defenses based thereon (see *Hospital for Joint Diseases v. Allstate Ins. Co., 21 AD 3d 348, 800 N.Y.S. 2d 190 [2005]; Nyack Hosp. v. Metropolitan Prop. & Cas. Ins. Co., 16 AD 3d 564, 791 N.Y.S. 2d 658 [2005]; New York Hosp. Med. Ctr. Of Queens v. New York Cent. Mut. Fire Ins. Co., 8 AD 3d 640, 779 N.Y.S. 2d 548 [2004]).*

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 11th Jud Dists 2003]).

In the event an insurer relies on a peer review report to demonstrate that a particular service was medically unnecessary the peer reviewer's opinion must be supported by sufficient factual evidence or proof, and cannot simply be conclusory, or may be supported by evidence of generally accepted medical and/or professional practice or standards. See *Nir v. Allstate Insurance Company,* 2005 NY Slip Op 25090; 7 Misc.3d

544; 796 N.Y.S.2d 857; 2005 N.Y. Misc. LEXIS 419 and *Citywide Social Work & Psy. Serv. P.L.L.C. v. Travelers Indemnity Co.,* 3 Misc. 3d 608; 777 N.Y.S.2d 241; 2004 NY Slip Op 24034.

In the event an insurer's evidence rebuts the inference of medical necessity, by proof in admissible form, establishing that the services were not medically necessary and if such evidence is not refuted by the Applicant such proof may entitle the insurer to judgment in its favor. See *A. Khodadadi Radiology, P.C. v. NY Central Mutual Fire Insurance Co.*, Supreme Court, Appellate Term 2nd and 11th Judicial Districts, 2007 NY Slip Op 51342 (U); 16 Misc.3d 131 (A).

11 N.Y.C.R.R. § 65-4.5 (o) (1) provides, in part, as follows:

> "(o) *Evidence.* (1) The 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". (Emphasis Added).

On February 6, 2018 the patient was examined by Suman Brahmbhatt, M.D. on behalf of the Respondent. The examination revealed that ranges of motion of the cervical spine were all normal and performed without apparent difficulties. Cervical lordosis was preserved. There was no cervical paraspinal tenderness to palpation and no spasm in the cervical paraspinals and trapezius bilaterally. Spurling Test was negative bilaterally. The radial pulse was present with Adson's Test. Examination of the thoracic-lumbar spine revealed normal ranges of motion performed without apparent difficulty. There was no tenderness or spasm. Straight Leg Raise Test in the supine and seated position was without any discomfort. Examination of the left wrist/hand revealed no swelling or tenderness, normal ranges of motion and no joint line tenderness. Tinel's Test, Phalen's Test, and Finkelstein's Test were all negative. Examination of the hand revealed no swelling or tenderness. Ranges of motion of the thumb were normal. Ranges of motion of the fingers were normal. Upper and lower extremity reflexes were 2+ symmetrical bilaterally. Upper and lower extremity muscle grading was 5/5 bilaterally. Hoffman Test was normal. There was no clonus. There was a normal sensory examination. The patient had a normal gait. The "Diagnostic Impression" was cervical derangement/sprain/strain resolved; thoracic-lumbar derangement/sprain/strain, resolved; and left wrist/hand derangement/sprain/strain resolved. At the conclusion of the examination, including a review of the patient's medical records, Dr. Brahmbhatt stated that the patient needed no further PM&R treatment including follow-up, physical therapy, massage therapy, pain management and diagnostic testing. In view of the findings and opinions contained in this report the Respondent terminated further no-fault benefits effective February 25, 2018.

When a report of an Independent Medical Examination provides a factual basis and medical rationale for an opinion that further services were not medically necessary, it is the Applicant's obligation to come forward with evidence sufficient to refute that

showing. See *AJS Chiropractic, P.C. v. Mercury Ins. Co.*, 22 Misc.3d 133 (A), 880 N.Y.S.2d 871 (Table), 2009 N.Y. Slip Op. 50208 (U), 2009 WL 323421 (App. Term 2nd , 11th & 13th Dists. Mar. 12, 2009).

I find that the report of Suman Brahmbhatt, M.D. provides a sufficient factual basis and medical rationale for the opinion that the services billed were not medically necessary and therefore the burden shifts to the Applicant to refute the opinion that these services were not medically necessary. See *Delta Diagnostic Radiology, P.C. v. Progressive Casualty Ins. Co.*, 21 Misc.3d 142A (App Term 2d & 11th Jud Dist 2008); *Crossbridge Diagnostic Radiology, PC v. Progressive Casualty Ins. Co.*, 20 Misc.3d 143A (App Term 2d & 11th Jud Dist. 2008).

On February 7, 2018 the patient was examined by Demetrious Mikelis, M.D. At that time the patient complained of radiating low back pain. The patient had physical therapy, a TENS unit, a lumbar epidural steroid injection and massage therapy. The patient stated that the pain in the lower back was 3-5 out of 10. The examination revealed tenderness and spasms and restricted ranges of motion. There was lower extremity reduced motor strength and altered sensation. The "Diagnosis" was herniated lumbar intervertebral disc; bilateral lumbar nerve root lesions. Chiropractic treatment, physical therapy and lumbar epidural steroid injections were recommended. Similar findings and recommendations were made by Dr. Mikelis on April 4, 2018 and May 9, 2018

There is also a report of a February 22, 2018 examination of the patient by Silvia Geraci, D.O. At that time the patient complained of pain in the low back radiating to the right lower extremity. Examination of the lumbar spine revealed reduced ranges of motion, reduced reflexes, a positive Straight Leg Raise Test on the right, reduced motor strength in the lower extremities and normal sensation. The "Diagnosis" was herniated lumbar intervertebral disc; lumbar radiculitis; and lumbar spine strain. No diagnostic tests were recommended and the patient indicated that no further intervention was needed at that time. Similar findings and recommendations were made by Dr. Geraci on April 26, 2018.

Upon consideration of the arguments of counsel and after a thorough review of all submissions I find that Respondent has submitted sufficient evidence to meet its *prima facie* burden of demonstrating that the services at issue were not medically necessary and to justify its termination of further no-fault benefits effective February 25, 2018 and that Applicant's evidence is insufficient to refute Respondent's evidence. Applicant's claims for reimbursement are, therefore, 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 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 Suffolk

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

08/30/2019
(Dated)

Henry Sawits

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:
fb7b4106dff133fad2b8091aa1c35957

Electronically Signed

Your name: Henry Sawits
Signed on: 08/30/2019