American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

New York Spine Specialists (Applicant)	AAA Case No.	17-17-1077-0199
	Applicant's File No.	2033241
- and -	Insurer's Claim File No.	0520880390101034
	NAIC No.	22055
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Jennifer Jacques, 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

1. Hearing(s) held on 09/12/2019
   Declared closed by the arbitrator on 09/12/2019

   Helen Mann Ruzhy, Esq. from Israel, Israel & Purdy, LLP (Great Neck) participated in person for the Applicant

   Chad Meyers, Esq. from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 236.94**, 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 the Applicant is entitled to reimbursement for medical services denied by the Respondent based upon an IME?

   The EIP is a 47-year-old female, injured as a driver by a motor vehicle on 05/27/16. Applicant seeks an amount of $236.94 for services performed on 09/25/17. Respondent denied payment based upon an IME by Ronald A. Light, M.D. on 02/13/17.

4. Findings, Conclusions, and Basis Therefor

I have completely reviewed all timely submitted documents contained in the ADR Center record maintained by the American Arbitration Association and considered all oral arguments. No additional documents were submitted by either party at hearing. No witnesses testified at hearing

ANALYSIS

Applicant has established its prima facie entitlement to reimbursement for no fault benefits as a matter of law based upon the submission of a properly completed claim form setting forth the amount of the loss sustained and that payment is overdue. Mary Immaculate Hospital v. Allstate Insurance Company, 5 AD 3d 742, (2 Dept. 2004).

The burden now shifts to respondent to establish a lack of medical necessity with competent medical evidence, which sets forth a clear factual basis (specifics of the claim) and medical rationale for denying the claim. Citywide Social Work and Psych Services, PLLC v. Allstate, 8 Misc. 3d 1025A (2005); Healing Hands Chiropractic v. Nationwide Assurance Co., 5 Misc. 3d 975 (2004).

Respondent must offer sufficient and credible medical evidence that addresses the standards in the applicable medical community for the services and treatment in issue; explains when such services and treatment would be medically appropriate, preferably with understandable objective criteria; and why it was not medically necessary in the instance at issue. An IME report asserting that no further treatment is medically necessary must be supported by a sufficiently detailed factual basis and medical rationale, which includes mention of the applicable generally, accepted medical/professional standards. Carle Place Chiropractic v. New York Central Mutual Fire Insurance Company, 19 Misc. 3d 1139 (A) (Dis. Ct. Nassau 2008). Furthermore, an IME report must set forth a factual basis and medical rationale for the collusion that further services are not medically necessary. Ying Eastern acupuncture PC v. Global Liberty Insurance, 20 Misc. 3d 144 (A), 873 NYS 2d 238 (App. Term 2d and 11th Dists. 2008).

Respondent timely denied the instant claim based upon an IME by Ronald A. Light, D.C., dated 02/13/17. Dr. Light examined the EIP and observed that her current complaints included pain in the lower back and left shoulder. Dr. Light's examination was completely normal and he found that the EIP's injuries were resolved.

Accordingly, I find Dr. Light's IME report sufficient to set forth a factual basis and medical rationale for the conclusion that further services were not medically necessary. E.g., Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), 873 N.Y.S.2d 238 (Table), 2008 N.Y. Slip Op. 51863(U), 2008 WL 4222084 (App. Term 2d & 11th Dists. Sept. 3, 2008).

It is the Applicant's burden, ultimately, to establish the medical necessity of the services at issue. See Insurance Law § 5102; Shtarkman v. Allstate Insurance Co., 2002 NY Slip

Op 50568(U), 2002 WL 32001277 (App. Term 9th & 10th Jud. Dists. 2002) (burden of establishing whether a medical test performed by a medical provider was medically necessary is on the latter, not the insurance company).

Applicant has failed to submit an affidavit from a health care practitioner, which meaningfully referred to, let alone rebutted, the conclusions set forth in the report. Pan Chiropractic , PC v. Mercury Insurance Co, 24 Misc. 3d 136 (A) (App Term 2d, 11th and 13th Jud Dist. 2009). 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 2 and 11 Judicial Districts, 2007 NY Slip Op nd th 51342 (U); 16 Misc.3d 131 (A).

In support of its position, Applicant submitted medical treatment notes on the date of service (09/25/17) and other treatment notes from June and July. The treatment notes dated June and July with Beacon Acupunture and Dr. Watson Chiropractic, lacked a comprehensive narrative and were predominately raw data of the treatment - establishing that the treatment occurred. The progress notes on the date of service included a comprehensive narrative; however, there were no other progress notes within thirty days of the service that established the need or lack thereof for ongoing medical treatment consisting of a comprehensive narrative.

Decision

I find that the EIP's medical records are insufficient to refute Respondent's burden of proof. During her evaluation with Dr. Light, the EIP indicated that she was currently working on a full time basis with limitations. I find Dr. Light's evaluation of the EIP to be more persuasive on the issue of medical necessity.

Based upon the reasons forth above, the claim is denied in its entirety.

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

09/14/2019
(Dated)

Jennifer Jacques

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:
ab391d30549be593adf2d8d42d99ad46

Electronically Signed

Your name: Jennifer Jacques
Signed on: 09/14/2019