American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

New York Spine Specialists (Applicant)	AAA Case No.	17-17-1081-8930
	Applicant's File No.	2044343
- and -	Insurer's Claim File No.	0549446670101016
	NAIC No.	22055
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Carolynn Terrell-Nieves, 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: Claimant

1. Hearing(s) held on 09/17/2019
   Declared closed by the arbitrator on 09/17/2019

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

   Heather Pliszak from Geico Insurance Company 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

   The Applicant seeks reimbursement for charges for an office visit performed on 10/23/17 after a 2/17/16 motor vehicle accident. Respondent issued a global denial dated 5/25/16 cutting off further orthopedic treatment, surgery, physical therapy and massage therapy effective 5/26/16 based upon the IME of Dr. John R. Denton. 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.

4. Findings, Conclusions, and Basis Therefor

Applicant has established its prima facie entitlement to reimbursement for no fault benefits 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). Westchester Medical Center v. Lincoln General Ins Co, 60 AD 3d 1045 (2 Dept. 2009). Respondent's denials indicate the date on which the claim was received adequately establishes that the claimant sent and that the defendant received the claim. Ultra-Diagnostic Imaging v. Liberty Mutual Insurance Company, 9 Misc. 3d 97, 804 NYS 2d 532 (App. Term 9th and 10th Districts 2005).

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. Respondent's IME report was credible and objectively unremarkable.

The EIP advised Dr. Denton that he was a pedestrian hit by a motor vehicle on 2/17/16.. He has complaints of neck, low back pain and left shoulder and left hip. Range of motion to the cervical and lumbar spine (by goniometer) was normal. There was no spasm, tenderness, atrophy or swelling. Spurling and straight leg raise tests were negative as were distraction and compression tests. The EIP was neurologically intact; motor strength was 5/5, DTR 2+ and sensation unaltered. Diagnosis was resolved cervical, thoracic, lumbar, left shoulder, and left hip sprain strain. Examination of the right hip was normal. The IME report herein sets forth a factual basis and medical rationale for its conclusions. AJS Chiropractic, PC v. Mercury Ins Co, 22 Misc. 3d 133 (A), 980 NYS 2d 871 (App Term 2d & 11 Jud Dist. 2009). The Respondent established a reasonable factual basis and medical rationale with its expert opinion as to the medical necessity for the disputed treatment.

Applicant must now meaningfully refer to or rebut the findings set forth in the IME report. Yklik, Inc v. Geico Ins. Co, 2010 NY Slip Op 51336(u) (App Term 2 , 11 and 13 Jud Dist. 7/22/10). In the absence of such a rebuttal, the claim may be denied. A. Khodadadi Radiology, PC v. NY Cent Mut. Ins. Co, 1 6 Misc. 3d 131 (A), 2007 NY Slip Op 51342[U] (App. Term 2 and 11 the Jud Dist. 2007). The Applicant has failed to submit an affidavit from a health care practitioner which meaningfully referred to, let alone rebutted, the conclusions set forth in Dr. Denton's report. I further find that the medical records submitted although the Applicant argued were contemporaneous Page 2/5 4. 5. 6. failed to convince me as to the medical necessity for the continued treatment

or office visit. Pan Chiropractic , PC v. Mercury Insurance Co, 24 Misc. 3d 136 (A) (App Term 2d, 11 and 13 Jud Dist. 2009). Following a thorough review of all the documentation submitted, I find the Applicant has failed to rebut respondent's reasonable factual basis and medical rationale with its expert opinion as to the necessity for the continued treatment. The claim 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 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, Carolynn Terrell-Nieves, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

10/15/2019
(Dated)

Carolynn Terrell-Nieves

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:
9b017e9594dff03f5751cb5ca06bccba

Electronically Signed

Your name: Carolynn Terrell-Nieves
Signed on: 10/15/2019