American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

New York Spine Specialists (Applicant)	AAA Case No.	17-18-1095-6071
	Applicant's File No.	2109088
- and -	Insurer's Claim File No.	11-3F62-965
	NAIC No.	25143
State Farm Fire & Casualty Company (Respondent)		

ARBITRATION AWARD

I, Anthony Kobets, 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 08/07/2019, 10/02/2019
   Declared closed by the arbitrator on 10/02/2019

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

   Bryan Visnius, Esq. from De Martini & Yi, LLP 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 made by the parties regarding the issues to be determined.

   At the hearing, the parties' representatives stipulated to the timely service of the bill and denial, to Applicant's prima facie burden and to the amount in dispute being in accordance with the applicable provisions of the NewYork State Workers' Compensation Fee Schedule.

3. Summary of Issues in Dispute

   In dispute is the Applicant's bill totaling $92.94 for a medical evaluation performed on the patient (MH) on 4/13/18 as a result of injuries alleged to have been sustained in a motor vehicle accident on October 4, 2013.

Respondent denied the claims based upon the results of an Independent Medical Examination (IME) performed by Dr. Dorothy Scarpinato, M.D. on 1/6/18. Was the Applicant entitled to reimbursement for the services provided to the EIP?

4. Findings, Conclusions, and Basis Therefor

I have reviewed all documents as available in the ADR Center as of the date of this hearing pertaining to this case. This case was decided based on the submissions of the Parties as contained in the Electronic Case Folder maintained by the American Arbitration Association and the oral arguments of the parties at the hearing. There was no witness testimony at the hearing.

At the hearing, the parties' representatives stipulated to the timely service of the bill and denial, to Applicant's prima facie burden and to the amount in dispute being in accordance with the applicable provisions of the NewYork State Workers' Compensation Fee Schedule.

The Patient (MH) was a 66 year old male driver who was allegedly involved in an automobile accident on October 4, 2013. Thereafter on 4/13/18, he underwent a medical evaluation performed by the Applicant. Applicants seek no-fault reimbursement for these services.

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, 774N.Y.S. 2d 564 [2004]; Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784 N.Y.S. 2d918, 2003 NY Slip Op 51701U [App Term, 2d & 11th Jud Dists]).

Respondent denied the bill in dispute herein based upon an IME conducted by Dr Dorothy Scarpinato, M.D. dated 1/6/18. The patient presented to the IME with complaints of pain in his neck and right shoulder. Examination of the cervical spine revealed complaints of tenderness with full range of motion, normal reflexes, full motor strength and no sensory deficits. Cervical orthopedic tests were not documented. The examination of the right shoulder was unremarkable and the diagnosis was resolved cervical strain and resolved right shoulder sprain. Dr. Scarpinato concluded that "the claimant's original injuries of cervical spine and right shoulder pain are causally related to the accident of 10/14/13. However, the recent treatment the claimant received is not causally related to motor vehicle accident of 10/04/13 due to a three year gap in treatment." Respondent's cousel argued that the Respondent met their burden regarding a lack of medical necessity and causation.

A treatment or service is medically necessary if it is "appropriate, suitable, proper and conducive to the end sought by the professional health service in consultation with the patient. It means more than merely convenient or useful treatment or services, but treatment or services that are reasonable in light of the patient's injury, subjective

and objective evidence of the patient's complaints of pain, and the goals of evaluating and treating the patient." Fifth Avenue Pain Control Center v. Allstate, 196 Misc. 2d 801, 807-808 (Civ. Ct. Queens Cty. 2003). Medically necessary treatment or services must be "consistent with the patient's condition, circumstances and best interest of the patient with regard to the type of treatment or services rendered, the amount of treatment or services rendered, and the duration of the treatment or services rendered." Id. Medical services are compensable where they serve a valid medical purpose. Sunrise Medical Imaging PC v. Lumbermans Mutual, 2001 N.Y. Slip Op. 4009.

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 11thJud 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 11thJud Dists 2003]).

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 Mut. Fire Ins Co., 19 Misc.3d 1139(A), 866 N.Y.S.2d 90 (Table), 2008 N.Y. Slip Op. 51065(U), 2008 WL 2228633 (Dist. Ct., Nassau Co., May 29, 2008, Andrew M. Engle, J.). An IME doctor must establish a factual basis and medical rationale for his asserted lack of medical necessity for future health care services. E.g., Ying Eastern Acupuncture, P.C. v. Global Liberty Insurance, 20 Misc.3d 144(A), (App. Term 2d & 11th Dists. Sept. 3, 2008).

"Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity (see Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11th ed])." West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 824 N.Y.S.2d 759 (Table), 2006 N.Y. Slip Op. 51871(U) at 2, 2006 WL 2829826 (App. Term 2d & 11th Dists. Sept. 29, 2006); A. Khodadadi Radiology PC v. NY Central Mutual Fire Ins. Co., 2007 NY Slip Op 51342(U).

Applicant's counsel argued that the IME failed to meet its burden regarding the lack of medical necessity and causation for the services rendered by disregarding the patient's subjective complaints as well as the objective positive findings contained in the IME

report and the contemporaneous medical records. Applicant also provided a rebuttal report by Dr. Sebastian Lattuga, M.D., wherein he reviewed the patient's medical records including the IME report by Dr. Scarpinato and indicated that "I oppose these conclusions. As documented in the medical reports attached hereto, the examination findings of the patient's treating physicians before and after the IME clearly indicate that the patient had yet to reach pre-injury status. Also, according to the findings upon diagnostic testing, the IME doctor's diagnosis of resolved cervical spine strain injury was inaccurate. Please refer to the MRI report attached hereto, which show disc bulges, disc herniations, nerve root impingement and other injuries that are more severe than the strain injury diagnosed by the IME doctor. Accordingly, I oppose the IME doctor's diagnosis of resolved strain injury, which did not accurately reflect the actual severity of the patient's injuries. Please refer to the medical reports attached hereto detailing the patient's ongoing injuries before and after the IME."

The evidence herein demonstrated that the patient underwent an MRI of the cervical spine on 11/6/13, which revealed Straightening of the cervical lordosis with left-sided disc herniations from C3-C4 through C6-C7 with impingement upon left exiting C6 nerve root at C5-C6 and probable left exiting C7 nerve root at C6-C7; and multilevel disc desiccation, disc bulging and anterior spondylosis in the mid-to-lower cervical spine without acute fracture or cord compression.

On 11/21/17, the patient was examined by Dr. Billy Ford, M.D. and presented with complaints of neck pain radiating to the bilateral shoulders with numbness, tingling and dysesthesias. Examination of the cervical spine revealed decreased range of motion with decreased reflexes and decreased motor strength in right finger abductors. Senseory examination revealed altered sensation in bilateral C6 and C7. The diagnosis was cervical nerve root impingement; herniated cervical intervertebral disc. The treatment plan included conservative care, epidural injections and medication.

On 11/21/17, the patient underwent a cervical epidural steroid injection under fluoroscopic guidance. The diagnosis was cervical sprain, radiculopathy, HNP. The indication noted "failure of conservative management and chronic pain..."

On 12/12/17, the patient was examined by Dr. Billy Ford, M.D. and presented with complaints of neck pain radiating to the bilateral shoulders with numbness, tingling and dysesthesias. Examination of the cervical spine revealed spasms, tenderness, decreased range of motion with decreased reflexes and decreased motor strength in right finger abductors. Senseory examination revealed altered sensation in bilateral C6 and C7. The diagnosis was cervical nerve root impingement; herniated cervical intervertebral disc. The treatment plan included conservative care, epidural injections and medication.

On 1/12/18, the patient was examined by Dr. D. Mikelis, M.D. and presented with complaints of neck pain. Examination of the cervical spine revealed decreased range of motion with spasms and tenderness. Sensation was altered in bilateral C6-C7

and motor exam was within normal limits. The diagnosis was cervical nerve root impingement and HNP. The treatment plan included conservative care, epidural injections and medication.

On 4/13/18, the patient was reexamined by Dr. D. Mikelis, M.D. and presented with complaints of neck pain. Examination of the cervical spine revealed decreased range of motion with spasms and tenderness. Sensation was altered in bilateral C6-C7 and motor exam was within normal limits. The diagnosis was cervical nerve root impingement and HNP. The treatment plan included conservative care, epidural injections and medication.

Based upon a review of the evidence herein and the arguments of counsel, I find that the Respondent has not met its burden of providing a sufficient medical rationale or factual basis to justify a lack of medical necessity for the medical evaluation performed on the patient on 4/13/18. Dr. Scarpinato did not adequately explain the patient's ongoing symptomology and objective positive test results documented in the medical records including the IME report. In addition, I find that Dr. Scarpinato's IME report was unpersuasive and overly conclusory without the necessary detailed medical examination or factual basis to support it. There were insufficient orthopedic tests performed and the positive findings noted were all attributed to the patient's subjectivity without a sufficient explanation or basis for this conclusion. An IME doctor who describes restrictions in range of motion as "self-restricted" must explain or substantiate, with objective medical evidence, the basis for such a conclusion. E.g., Cuevas v. Compote Cab Corp., 61 A.D.3d 812, 878 N.Y.S.2d 124 (2d Dept. 2009); Torres v. Garcia, 59 A.D.3d 705, 874 N.Y.S.2d 527 (2d Dept. 2009). "[A]n IME is a snapshot of the injured party's medical condition as of the date of the IME. The opinion of the doctor conducting an IME and issuing a report that no further treatment or testing is needed is nothing more than an expert's opinion that at the time the examination was conducted the claimant did not need any further treatment or testing." Amato v. State Farm Ins. Co ., 30 Misc.3d 238, 910 N.Y.S.2d 637 (2010). I am persuaded by the patient's medical records that the services herein were reasonable based on the patient's continued symptomology and medically necessary in order to provide a proper diagnosis and treatments. I am also not persuaded that the patient's medical condition was resolved based on the positive objective findings including spasms, decreased sensation, decreased reflexes, decreased motor strength and decreased ranges of motion noted in the contemporaneous medical records. To the extent medical reports can be read as expressing an opinion regarding the patient's need for additional treatment, in the absence of objection that opinion may be weighed, along with the other evidence, in determining whether plaintiff met its burden of establishing the medical necessity of the post-IME treatments. All-In-One Medical Care, P.C. v. Government Employees Ins. Co. , 43 Misc.3d 726, 982 N.Y.S.2d 853 (Dist. Ct. Nassau Co. 2014).

I find that Dr. Scarpinato's IME report was unpersuasive and overly conclusory without a sufficient factual basis and medical rationale to justify the position that the services herein were not causally related. I find that the patient's medical records were more persuasive that the services herein were reasonable and causally related to resolve an ongoing condition. Where an IME report provides a factual basis and medical rationale

for an opinion that services were not medically necessary, and the claimant fails to present any evidence to refute that showing, the claim should be denied, AJS Chiropractic, P.C. v. Mercury Ins. Co., 22 Misc.3d 133(A), (App. Term 2d & 11th Dist. Feb. 9, 2002), as the ultimate burden of proof on the issue of medical necessity lies with the claimant. See Insurance Law § 5102; Wagner v. Baird, 208 A.D.2d 1087 (3d Dept. 1994).

Furthermore, in Mount Sinai v. Triboro Coach, 263 A.D. 2d. 11 (Second Dep't, 1999), the Court stated that the insurer has the burden of coming forward with proof in an admissible form to establish the fact or evidentiary foundation for its belief that the patient's condition was unrelated to the motor vehicle accident. Moreover, the insurer must show that the injury was not related to the accident at all. It must show how, when and where the injury happened and that it was not aggravated or exacerbated by the accident (emphasis added). The insurer's proof may not be vague, conclusory, inconsistent or unsupported by records. In Kingsbrook Jewish Medical Center v. Allstate Ins. Co., 61 A.D.3d 13, (A.D. 2d. Dep't, 2009) the Appellate Division, ruled that exacerbations of pre-existing conditions are covered by No-Fault, and that causation is presumed under the New York No-Fault law. An expert's affirmation is needed to provide a factual foundation for an insurance carrier's good faith belief that an alleged injury did not arise out of an insured accident; speculation or wishful thinking does not suffice. Mt. Sinai Hospital v. Triboro Coach Inc., 263 A.D.2d 11, 699 N.Y.S.2d 77 (2d Dept. 1999). Dr. Scarpinato's report in this matter is deficient, among other reasons, because it lacks sufficient factual support and medical rationale to justify the position that the services herein were not causally related. I find that the patient's medical records demonstrated that the services herein were causally related and reasonable to resolve an ongoing condition. I am also persuaded that the patient's injuries visualized and treated at the time of the 4/13/18 evaluation were consistent with the patient's mechanism of injury as a direct result of the motor vehicle accident. An insurer fails to come forward with proof in admissible form to demonstrate the fact or the evidentiary foundation for its belief that the patient's treated condition was unrelated to his or her automobile accident where the affidavit of its medical expert is conclusory, speculative, and unsupported by the evidence. E.g., New York & Presbyterian Hospital v. Selective Ins. Co. of America, 43 A.D.3d 1019, 842 N.Y.S.2d 63 (2d Dept. 2007). **Based upon the aforementioned, I find that the Respondent has failed to sufficiently establish that the services were not medically necessary or causally related and grant Applicant's claim in the amount of $92.94.** This decision is in full disposition of all claims for No-Fault benefits presently before this Arbitrator. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of the hearing.

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	**04/13/18 - 04/13/18**	**$92.98**	**$ 92.98**	**Awarded: $92.98**
Total			**$92.98**	**Awarded: $92.98**	

B. The insurer shall also compute and pay the applicant interest set forth below. 05/22/2018 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 arbitration is commenced by the claimant, i.e., the date the claim is received by the American Arbitration Association, unless arbitration is commenced within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the date the denial is received by the claimant. See generally, 11 NYCRR 65-3.9. Where a motor vehicle accident occurs after Apr. 5, 2002, interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 11 NYCRR 65-3.9(c). The Superintendent and the New

York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely. LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 N.Y.3d 217 (2009).

C. Attorney's Fees

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

As this matter was filed **after** February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 11 NYCRR 65-4.6(d).

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 Nassau

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

10/18/2019
(Dated)

Anthony Kobets

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:
7b61cd076d300ed4421b014d51b505ff

Electronically Signed

Your name: Anthony Kobets
Signed on: 10/18/2019