American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

New York Spine Specialists (Applicant)	AAA Case No.	17-18-1098-0711
	Applicant's File No.	2121719
- and -	Insurer's Claim File No.	0315280000101038
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Nicholas Tafuri, 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 (AA)

1. Hearing(s) held on 10/31/2019
   Declared closed by the arbitrator on 10/31/2019

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

   Diane Phillips, Esq. 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

   EIP, AA, is a 58-year-old male, who was the driver of a motor vehicle involved in an accident on September 19, 2017. Following the accident, EIP sought medical treatment. Health services were provided by Applicant on May 10, 2018.

   Applicant's claim for reimbursement of the health services provided, a follow up examination, was denied by Respondent based on an Independent Medical Examination ("IME") by Dr. Bradley L. White, held on 12/18/17.

The issues presented is whether Applicant is entitled to no-fault reimbursement for health services denied based on an IME?

4. Findings, Conclusions, and Basis Therefor

I have reviewed the documents contained in the ADR Center Record 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. Pursuant to 11 NYCRR 65-4 (Regulation 68-D), §65-4.5 (o) (1), an 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 case was decided on the submissions of the Parties as contained in the ADR Center Record maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses.

EIP, AA, is a 58-year-old male, who was the driver of a motor vehicle involved in an accident on September 19, 2017. Following the accident, EIP sought medical treatment. Health services were provided by Applicant on May 10, 2018.

Applicant establishes a prima facie case of entitlement to reimbursement of its claim by the submission of a completed NF-3 form or similar document documenting the facts and amounts of the losses sustained, and by submitting evidentiary proof that the prescribed 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. See, Mary Immaculate Hospital v. Allstate Insurance Company, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept. 2004). I find Applicant establishes a prima facie case. The burden then shifts to the Respondent to prove that the bill in question was properly denied.

Applicant's claim for reimbursement of the health services provided, a follow up examination, was timely denied by Respondent based on an Independent Medical Examination ("IME") by Dr. Bradley L. White, held on 12/18/17.

Medical Necessity

The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment. Kingsborough Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D. 3d 13 (2d Dep't. 2009). See also Channel Chiropractic PC v. Country Wide Ins. Co., 38 AD 3d. 294 (1st Dep't. 2007). An insurance carrier must at a minimum establish a detailed factual basis and a sufficient medical rationale for asserting lack of medical necessity. See Delta Diagnostic Radiology PC v. Progressive Casualty Ins. Co., 21 Misc. 3d. (142A) (App. Term 2d Dep't. 2008).

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); Carle Place Chiropractic v. New York Central Mut. Fire Ins. Co., 19 Misc.3d 1139(A), (Dist. Ct., Nassau Co., Andrew M. Engle, J., May 29, 2008).

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).

On December 18, 2017, EIP submitted to a medical examination ("IME") with Dr. Bradley L. White, M.D. The IME resulted in the termination of orthopedic and related health service benefits effective December 30, 2017. In his report Dr. White advises that EIP complains of back and left leg pain. Dr. White observes that EIP ambulates with a normal gait. On examination of the lumbar spine, Dr. White notes a 10-degree loss in range of motion in flexion, however, remaining ranges of motion are normal. There is no muscle spasm, and no tenderness upon palpation. Straight leg raise test is negative bilaterally. Motor strength of the lower extremities is 5/5. Sensation to light touch and deep tendon reflexes are within normal limits. Muscle tone is normal. There is no muscle wasting. Examination of the left knee reveals no effusion, no deformity, no swelling, no contracture, no joint line tenderness, no crepitus, and no cruciate or collateral ligamentous laxity. Range of motion is reduced by10 degrees, however, all orthopedic tests are negative: Lachman test, McMurray test, Anterior Drawer test and Posterior Drawer test. Quadriceps strength is 5/5 and there is no quadriceps lag. Dr. White diagnosis: lumbar spine strain/sprain, resolved; left knee sprain/strain

resolved. Dr. White concludes there is no orthopedic disability. Lumbar spine and left knee exam did not reveal any clinical findings including spasms and/or positive tests to support subjective complaints of pain. Decreased range of motion was minimal and subjective, and does not present any functional disability. Therefore, there is no need for orthopedic treatment.

Despite Applicant's arguments to the contrary, I find the results of this examination presented a medical rationale as to why further benefits were terminated. Based upon the foregoing, Respondent has set forth a cogent medical rationale in support of its defense. Since Respondent has factually demonstrated the services rendered were not medically necessary, the burden shifts to Applicant who bears the ultimate burden of persuasion.

For Applicant to prove that the disputed treatment was medically necessary, it must demonstrate that "the treatment, procedure, or service (was) ordered by a qualified physician...based on an objectively reasonable belief that it will assist in the patient's diagnosis and treatment and cannot be reasonably dispensed with". Nir v. Progressive Insurance, NYLJ, April 14, 2005, p.19, col. 1 (Civil Ct Kings County, J. Nadelson). Moreover, "(s)uch treatment, procedure, or service must be warranted by the circumstances as verified by a preponderance of credible and reliable evidence, and must be reasonable in light of the subjective and objective evidence of the patient's complaints." Id.

To counter the IME review findings and conclusions, Applicant relies on submitted medical records, including the report of 1/18/18 and MRI reports of 10/25/17 and 10/27/17. The report of 1/18/18 by Dr. Andrew Cordiale notes EIP's complaints of pain to the back, left leg and neck. The severity of pain on a scale of 1 to 10 is as follows: for the back 3 out of 10 and for the neck 3 out of 10. Apparently, the left leg pain is negligible, since a pain scale for the leg is not reported. The exam notes restrictions in ranges of motion of the cervical spine and reduced reflexes. However, no orthopedic testing is conducted. The lumbar spine exam also reveals restrictions in ranges of motion of the spine and reduced reflexes. However, no orthopedic testing is conducted. No examination of EIP's left leg/left knee is conducted. Dr. Cordiale diagnosis EIP with cervical and lumbar spine pain and herniated discs. The report of 5/10/18 for the subject date of service, mirrors the evaluation report of 1/18/18.

Upon a review of the submissions and medical records and considering the arguments presented by the parties' representatives, I find that Applicant has failed to meet the burden of persuasion in rebuttal. Applicant's submissions did not factually rebut the assertions of Dr. White that continued orthopedic treatment was medically unnecessary. In comparing the submitted evidence, I find I am more persuaded by the detailed examination report by Dr. White. Applicant's medical record of 1/18/18 and 5/10/18 are devoid of any orthopedic testing conducted of EIP's spine and left leg/left knee. As such, Applicant's submissions do not meet the necessary burden. I find that the IME report presents a sufficient factual basis and medical rationale to support Respondent's defense of a lack of medical necessity, which defense Applicant has failed to adequately refute.

Respondent's denial based on medical necessity is sustained, and Applicant's claim for date of service 5/10/18 is denied.

This decision is in full disposition of all claims for no-fault benefits presently before this arbitrator.

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

11/14/2019
(Dated)

Nicholas Tafuri

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:
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Electronically Signed

Your name: Nicholas Tafuri
Signed on: 11/14/2019