American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Jeffrey Schnapper,D.C (Applicant)	AAA Case No.	17-18-1109-6822
	Applicant's File No.	FDNY18-30952
- and -	Insurer's Claim File No.	160960
	NAIC No.	29599
U.S. Specialty Insurance Company (Respondent)		

ARBITRATION AWARD

I, Farheen Sultan, 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 04/22/2020
   Declared closed by the arbitrator on 04/22/2020

   Melissa Pirillo, Esq. from Fass & D'Agostino, P.C. participated in person for the Applicant

   Donald Kavanaugh, Esq. from Bruce Somerstein & Associates, P.C. participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 6,634.97**, was AMENDED and permitted by the arbitrator at the oral hearing.

   The amount in dispute was **amended to $6341.44** in accordance with the applicable fee schedule.

   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated that Applicant established its prima facie case of entitlement to No-Fault benefits and that Respondent's NF-10/Denial of Claim forms were timely issued. The parties also stipulated that there were no further issues with respect to the amount in dispute as amended.

3. Summary of Issues in Dispute

The Assignor, E.D., a 66 year old female, was the driver of a motor vehicle that was involved in an accident on 8/17/12. At issue in this case is $6341.44 (as amended) for chiropractic treatment provided on dates of service 4/3/13-5/22/15. Respondent denied f the claims on the basis of the IME of Dr. Pamela Baltsas and based on the 45 day rule. The issues to be determined are whether Respondent established its medical necessity and 45 day rule defenses.

4. Findings, Conclusions, and Basis Therefor

This case was decided based upon the submissions of the parties as contained in the electronic file maintained by the American Arbitration Association, and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in MODRIA for both parties and make my decision in reliance thereon.

45 Day Rule

Applicant establishes its prima facie entitlement to No-Fault benefits by submitting proof that its claim, on the statutory billing form, was mailed and received by the insurance company and that payment is overdue. Viviane Etienne Med. Care, P.C. v. Country-Wide Ins. Co., 25 N.Y. 3d 498, 14 N.Y.S. 3d 283 (2015). However, the claim must be submitted within 45 days of service ("45 Day Rule") and where the insurer denies a claim based on the 45 Day Rule, it must advise the Applicant that late notice will be excused if there is reasonable justification provided. St. Vincent's Hosp. & Medical Center v. Country Wide Ins. Co., 4 A.D.3d 748809 N.Y.S.2d 88 (2d Dept. 2005). The 45 Day Rule is a precludable defense and must be raised in a timely denial. Presbyterian Hosp. in the City of New York v. Maryland Cas. Co.,90 N.Y.2d 274, 683 N.E.2d 1 (1997); Central General Hosp. v. Chubb Group of Ins. Companies, 90 N.Y.2d 195681 N.E.2d 413 (1997). Based upon a review of the parties' submissions, i.e. the denials, I find that Applicant established that the bills were submitted to the Respondent for reimbursement. The burden shifts to the insurer to establish that it timely and properly denied the claims, and the basis of its denial.

Respondent denied the claims for dates of service: 1/04/14-1/08/14, 1/15/14-1/22/14, 2/07/14-2/19/14, and 2/21/14·2/28/14 based on the 45 day rule. However, the denials for these dates of service were issued more than 30 days after receipt of the claims and as such are not timely.

Accordingly, Applicant's claims for these dates of service are granted.

Medical Necessity

Respondent denied the claims for the remaining dates of service based on an IME.

An IME report must set forth a factual basis and medical rationale for the conclusion that further services are not medically necessary. Ying Eastern Acupuncture, P.C. v. Global Liberty Ins., 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). If the 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).

Where the IME report submitted by the insurer sets forth a factual basis and medical rationale for the conclusion that the assignor's injuries were resolved and that the treatment which is the subject of the claim lacked medical necessity, the report submitted in opposition must meaningfully refer to and rebut the IME findings. E.g., Premier Health Choice Chiropractic, P.C. v. Praetorian Ins. Co., 41 Misc.3d 133(A), 981 N.Y.S.2d 638 (Table), 2013 N.Y. Slip Op. 51802(U), 2013 WL 5861532 (App. Term 1st Dept. Oct. 30, 2013).

In support of its medical necessity defense Respondent submits the IME reports of Dr. Pamela Baltsas dated 3/13/13. Upon examination Dr. Baltsas found that the ranges of motion in the cervical, thoracic and lumbar spine were within normal limits on all planes. The results of all objective tests performed were negative and muscle strength was normal. Based on the examination, Dr. Baltsas diagnosed the Assignor with resolved sprains/strains and determined that no further chiropractic treatment was medically necessary.

I find Respondent's IME report is sufficient to establish Respondent's lack of medical necessity defense as to this claim. The burden now shifts to the Applicant as 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).

In rebuttal, Applicant submits the contemporaneous medical records of Dr. Jeffrey Schnapper dated 4/3/13 and 4/13/13. Dr. Schnapper notes decreased ranges of motion in the lumbar spine, segmental disfunction, muscle tenderness and spasm. Dr. Schnapper also notes positive orthopedic testing, i.e. positive Soto Hall test and positive Yeomen's test bilaterally. I find that the contemporaneous records are sufficient to refute the findings of the IME report.

Respondent argued that the findings throughout the Assignor's chiropractic treatment records are very similar and show similar complaints of pain, treatment and results. Respondent also argued that the chiropractic records incorrectly refer to the Assignor as

a male when she is in fact a female. I find that these arguments do not negate the validity of the Assignor's records and do not invalidate the contemporaneous examination findings and positive orthopedic testing that contradict and adequately refute the findings of Dr. Baltsas's IME exam. As such, I find that Applicant has established the medical necessity of the services at issue.

Accordingly, Applicant's claims are granted in their entirety as amended.

Any further issues raised in the hearing record are held to be moot and/or waived insofar as not specifically 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**	**Amount Amended**	**Status**
	Jeffrey Schnapper, D.C	**04/03/13 - 05/22/15**	**$6,634.97**	**$6,341.44**	**Awarded: $6,341.44**
Total			**$6,634.97**		**Awarded: $6,341.44**

B. The insurer shall also compute and pay the applicant interest set forth below. 10/31/2018 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

> Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. 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).

Based on the regulations, I find the date that interest shall accrue from is the date the Applicant requested arbitration in this matter. See, 11 NYCRR 65-3.9(c).

C. Attorney's Fees

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

> The insurer shall also pay the applicant for attorney's fees as set forth below. This case is subject to the provisions as to attorney fee promulgated in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.6. The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(d). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the total amount of first-party benefits and any additional first party benefits, plus interest thereon, for each applicant per arbitration or court proceeding, subject to a maximum fee of $1,360." Id.

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

05/02/2020
(Dated)

Farheen Sultan

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:
9eb9b1bc4d8ce9d0ca814eb2bea5dec1

Electronically Signed

Your name: Farheen Sultan
Signed on: 05/02/2020