American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Advanced Imaging Center (Applicant)	AAA Case No.	17-19-1135-2315
	Applicant's File No.	n/a
- and -	Insurer's Claim File No.	0440784312 SNM
Allstate Property and Casualty Insurance Company (Respondent)	NAIC No.	17230

ARBITRATION AWARD

I, Andrew Horn, 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, eligible injured person, EIP.

1. Hearing(s) held on 03/11/2020
   Declared closed by the arbitrator on 03/11/2020

   Anna Skowronska, Esq., from Law Office of Jeffrey Randolph, LLC, participated by telephone for the Applicant

   Thomas Cooke, Esq., from Law Offices of John Trop, participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 3,091.48**, 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

   In dispute is Applicant Advanced Imaging Center's claim as the assignee of a 48-year-old woman - a resident of Nanuet, New York -- injured in a motor vehicle accident on December 28, 2016, for reimbursement for x-rays of the cervical, thoracic and lumbar spine and right knee and magnetic resonance imaging (MRI) of the cervical and lumbar spine and right knee, which had been ordered by Dr. Renato Cappello, D.C. and performed by Dr. Steve Losik on February 8, 2017 in Newark, New Jersey.

While the x-rays revealed no fractures or dislocations, the disputed MRIs pertinently revealed disc herniations at C4-C5, C6-C7, L2-L3 and L4-L5 and a meniscal tear of the right knee.

Respondent Allstate Property and Casualty Insurance Company timely denied the claim relying on a peer review by its chiropractor Dr. Rory M. Ciuffo. The insurance carrier also contended that the charges for the testing was excessive.

Although the insurer did not pay for the x-rays, its peer reviewer did not explicitly opine as to their necessity (or lack thereof) and - to the contrary -- suggested that the standard of care included "plain film radiography."

Absent a factual basis and medical rationale, Respondent's denial of this portion of the claim is insufficient, conclusory, vague, or otherwise involves a defense which has no merit as a matter of law. Westchester Med. Ctr. v. Nationwide Mut. Ins. Co., 78 A.D.3d 1168 (2d Dept. 2010); Nyack Hosp. v. Metropolitan Prop. & Cas. Ins. Co., 16 A.D.3d 564, 565 (2d Dept. 2005).

Accordingly, Applicant is entitled to be paid for the x-rays.

4. Findings, Conclusions, and Basis Therefor

1.

In opining that performance of the MRIs deviated from accepted medical standards, Dr. Ciuffo stated that, "(f)or most patients with neck, back, knee, and shoulder pain, a diagnosis can be made with a history, physical exam, and plain film radiography," and, while "(n)eck and back pain have many causes, … the majority of patients will improve with conservative management." The peer reviewer contended that the provider's assignor's case was such an instance since, according to "the most contemporaneous office note (dated) January 30, 2017," "the claimant was responding well to the chiropractor's care," "was improved and … had demonstrated a reduction in the severity of his symptoms." Respondent's expert further pointed out that the medical record did not "describe an individual with persisting neurological sequelae nor d(id) it document persisting radicular symptoms to either the upper or lower limbs consistent with a specific anatomical level." Nor, according to Dr. Ciuffo, was there any record that assignor was "failing to respond to a course of therapy directed towards the knee," or any indication that he was "being considered as a surgical candidate." Although the peer reviewer acknowledged the positive findings, he maintained that "30% to 40% of asymptomatic young and middle-aged patients have changes in the intervertebral discs such as protusion or desiccation," and that a "similar percentage of middle-aged patients … have asymptomatic meniscus and rotator cuff tears."

Although Applicant's attorney sought to discredit Dr. Ciuffo's credibility by pointing out that the daily treatment notes showed no significant improvement, I find that neither did they document any persisting radicular complaints.

Inasmuch as the peer reviewer "demonstrated a factual basis and a medical rationale for his determination that there was no medical necessity for the services at issue here," "the burden shifted to (the provider) to present (its) own evidence of medical necessity." See Cappello v. Global Liberty Ins. Co. of N.Y., 57 Misc.3d 143(A) (App Term 1st Dept. 2017).

In order for an applicant to prove that the disputed expense was medically necessary, it must meaningfully refer to, or rebut, the conclusions set forth in the peer review.See High Quality Medical, P.C. v. Mercury Ins. Co., 26 Misc.3d 145(A) (App Term 2d, 11th & 13th Dists. 2010); Pan Chiropractic, P.C. v. Mercury Ins. Co., 24 Misc.3d 136(A) (App Term 2d, 11th & 13th Dists. 2009).

It is ultimately the provider who must prove, by a preponderance of the evidence, that the services were reasonable and necessary. See Dayan v. Allstate Ins. Co., 49 Misc.3d 151(A) (App Term 2d Dept. 2015); Park Slope Med. & Surgical Supply, Inc. v Travelers Ins. Co., 37 Misc.3d 19, 22 n (App Term 2d, 11th & 13th Dists. 2012).

As Applicant's attorney acknowledged, no rebuttal was submitted in response to the peer review and the provider instead relied solely on the treatment notes.

After careful consideration of both parties' evidence, I find that, after Respondent made its showing that the magnetic resonance imaging in question was not medically necessary, Applicant offered no evidence that meaningfully addressed, let alone rebutted, the peer reviewer's objections. See Rummel G. Mendoza, D.C., P.C. v. Chubb Indem. Ins. Co., 47 Misc.3d 156(A) (App Term 1st Dept. 2015).

Accordingly, Respondent's denial of this portion of the claim is upheld.

2.

An insurer is only required to pay for services in the amounts prescribed by the relevant fee schedule, see Oleg's Acupuncture, P.C. and Hereford Ins. Co., 58 Misc.3d 151(A) (App Term 2d, 11th & 13th Dists. 2018), but has the burden to establish that the amounts charged exceed the permitted amounts, see Rogy Med. P.C. v. Mercury Cas. Co., 23 Misc.3d 132(A) (App Term 2d, 11th & 13th Dists. 2009).

By statute and regulation, the fee schedules established by the New York State Workers' Compensation Board are expressly made applicable to claims under No-Fault Law. See Insurance Law §5108; 11 NYCRR §68.0, §68.1 (a) (1).

I am permitted to take judicial notice of, among other things, the workers' compensation fee schedule. See Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 20

(2d Dept. 2009); LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), (App Term 2d, 11th & 13th Dists. 2011); Natural Acupuncture Health, P.C. v. Praetorian Ins. Co., 30 Misc.3d 132(A) (App Term 1st Dept. 2011).

11 NYCRR §68.6, as amended, pertains to services performed on and after January 23, 2018 and provides that "a professional health service reimbursable under Insurance Law section 5102(a)(1) … performed outside this State with respect to an eligible injured person that is a resident of this state" shall be paid by the insurer at "the lowest of: (1) the amount of the fee set forth in the region of this State that has the highest applicable amount in the fee schedule for that service; (2) the amount charged by the provider; and (3) the prevailing fee in the geographic location of the provider."

Both parties agreed that the New Jersey Physicians' and ASC Fee Schedules, Physicians' Fees North, was the applicable fee schedule hereunder.

However, Respondent's attorney contended that only $291.57 was due and owing, notwithstanding that the fee-scheduled charges for the four billed codes total $409.78.

Although he opined that the subject testing was more appropriately billed under different codes, he is not necessarily qualified to rendered such opinion. See Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13 (2d Dept. 2009); Abraham. v. Country-Wide Ins. Co., 3 Misc.3d 130(A).

In sum, Applicant is awarded $409.78.

This award is in full disposition of all No-Fault benefit claims submitted to 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 applicant is AWARDED the following:

A.

Medical		**From/To**	**Claim Amount**	**Status**
	Advanced Imaging Center	**02/08/17 - 02/08/17**	**$3,091.48**	**Awarded: $409.78**
Total			**$3,091.48**	**Awarded: $409.78**

B. The insurer shall also compute and pay the applicant interest set forth below. 07/17/2019 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Inasmuch as Applicant did not file for arbitration within 30 days of receipt of Respondent's denial, the statutory tolling provision applies. Accordingly, the insurer shall pay interest on the claim totaling $409.78 from July 17, 2019, the date arbitration was initiated, until such time as payment is made.

C. Attorney's Fees

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

The insurer shall pay the applicant an attorney's fee, subject to a maximum fee of $1,360.00, in accordance with 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 Bronx

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

05/10/2020
(Dated)

Andrew Horn

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:
d8175184727079c8d680e29f85b0e934

Electronically Signed

Your name: Andrew Horn
Signed on: 05/10/2020