American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Westerleigh Chiropractic Associate (Applicant)	AAA Case No.	17-19-1141-3220
	Applicant's File No.	NA
- and -	Insurer's Claim File No.	0102310130101140
	NAIC No.	22063
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Antonietta Russo, 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 07/23/2020
   Declared closed by the arbitrator on 07/23/2020

   James Shook from Law Office of James C. Shook, PC participated by telephone for the Applicant

   Kaitlin Rogan from Geico Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,076.15**, 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 Assignor, a 41 year old female driver, was reportedly involved in a motor vehicle accident on April 11, 2019. Following the accident, Assignor suffered injuries which resulted in her seeking medical treatment. Thereafter, a treatment plan was recommended and Assignor underwent electrodiagnostic testing of the lower extremities on May 30, 2019. Applicant is seeking reimbursement for these services. The claim was timely denied based on a peer review of Dr. Ferrante and the only issue presented at the hearing was:

   1. Whether the Respondent's denial based on a lack of medical necessity predicated on a peer review was proper?

4. Findings, Conclusions, and Basis Therefor

The Applicant and the Respondent submitted documentary evidence in support of their respective positions. All such evidence is contained within MODRIA maintained by the American Arbitration Association, as of the date of the hearing. The below noted decision is based upon my review of the submitted evidence, along with the oral argument of the representatives present at the hearing.

As an initial matter, I find that Applicant has submitted sufficient credible evidence to establish a prima facie case of medical necessity. A medical provider establishes a prima facie showing of their entitlement to judgment as a matter of law by submitting evidentiary proof that the prescribed statutory billing forms had been mailed and received and that payment of no fault benefits was overdue. See, *Mary Immaculate Hospital v. Allstate Insurance Company*, 5 A.D.3d 742, 774 N.Y.S.2d 564 (2nd Dept.2004) Similarly, I find that the Respondent has proffered a timely denial which preserves the defense of fee schedule and medical necessity, pursuant to the peer review by Dr. Ferrante.

MEDICAL NECESSITY

Applicant, having established its prima facie case, the burden now shifts to the Respondent to demonstrate its defense of lack of medical necessity (*Alvarez v. Prospect Hosp.*, 68 N.Y.S.2d 320, 501 N.E.2d 572, 508 N.Y.S.2d [1986]; *A.B.Medical Services v. Geico Ins. Co*., 2 Misc 3d 26 [App Term 2d and 11th Jud Dists, 2003]). Respondent bears the burden of production in support of a medical necessity defense, which if established shifts the burden of persuasion to applicant. See generally, *Bronx Expert Radiology, P.C. v. Travelers Ins. Co.,* 2006 NY Slip Op 52116 (App. Term 1 Dept. 2006).

In order to support a lack of medical necessity defense respondent must "set forth a factual basis and medical rationale for the peer reviewer's determination that there was a lack of medical necessity for the services rendered." See, *Provvedere, Inc. v. Republic Western Ins. Co*., 2014 NY Slip Op 50219(U) (App. Term 2nd , 11th and 13th Jud. Dists. 20140.

The civil courts have held that a defendant's peer review or medical evidence must set forth more than just a basic recitation of the expert's opinion. The trial courts have held that a peer review report's medical rationale will be insufficient to meet respondent's burden of proof if: 1) the medical rationale of its expert witness is not supported by evidence of a deviation from "generally accepted medical" standards; 2) the expert fails to cite to medical authority, standard, or generally accepted medical practice as a medical rationale for his findings; and 3) the peer review report fails to provide specifics as to the claim at issue, is conclusory or vague. See generally, *Nir v. Allstate*, 7 Misc.3d 544 (N.Y. City Civ. Ct. 2005); See also, *All Boro Psychological Servs. P.C. v. GEICO*, 2012 NY Slip Op 50137(U) (N.Y. City Civ. Ct. 2012).

"Generally accepted practice is that range of practice that the profession will follow in the diagnosis and treatment of patients in light of the standards and values that define its calling." *Nir, supra.*

Respondent denied the claim in a timely fashion pursuant to the results of a peer review performed by Christopher Ferrante, D.C., dated July 8, 2019. In his report, Dr. Ferrante references the Assignor's medical records and concludes the services were unnecessary for the following reasons: 1) there is no substantiated need for the tests; 2) from a chiropractic point of view, the physical findings along with the MRI results would be adequate to identify the cause of a possibility of radiculopathy, without the need for neurodiagnositc testing; and 3) based on the chiro evaluation, it was noted the Assignor presented with lumbar radiculopathy. There was no indication of a peripheral nerve entrapment or other neurological disorder that would require differentiation with the testing. Based on Dr. Ferrante's report, Respondent denied the claim and disallowed payment.

I find that Respondent has factually demonstrated these items were not medically necessary. Accordingly, the burden now shifts to Applicant, who bears the ultimate burden of persuasion. See, *Bronx Expert*, *supra*.

In opposition to Respondent's contentions, Applicant maintains that the testing was necessary and relied on the medical records.The record includes the reports by Dr. Salvatore Germino, DC, the referring physician. The reports indicate the Assignor had complaints of worsening "marked" back pain with and evaluation that revealed moderately restricted range of motions, hypo-reflexia in the right patellar tendons, sensory deficits in the L4 and L5 areas and positive Yeoman's and Kemp's tests. The May 30th report by Dr. Germino indicates due to the worsening complaints, NCV/EMG lower extremities warranted to rule out L4 v. L5 radiculopathy v. distal neuropathy. "Pending results consider lumbar epidurals v. surgical referral."

In this matter, I am faced with conflicting opinions concerning the medical necessity for the disputed treatment herein. There are no legal issues to resolve. This dispute involves solely an issue of fact, that is, whether or not the treatment was medically necessary. Resolution of that fact is determined by which opinion is accepted by the trier of fact.

After carefully reviewing the reports, documents and opinions for each side, I find that the Applicant has addressed and rebutted the peer review to the extent that it has demonstrated by a preponderance of the evidence that the services at issue were medically necessary. Specifically, Applicant has set forth evidence of spinal injury which was unresolved by conservative care, and has refuted the peer reviewer's position that EMG/NCV studies were not necessary. Therefore, in reviewing all of the evidence, I find that the Applicant has set forth a more credible argument regarding the necessity of the underlying services.

Accordingly, I find in favor of Applicant and grant their claim.

Any further issues raised in the record are held to be moot and/or waived insofar as not raised at the time of the hearing. 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 applicant is AWARDED the following:

A.

Medical		**From/To**	**Claim Amount**	**Status**
	Westerleigh Chiropractic Associate	**05/30/19 - 05/30/19**	**$1,076.15**	**Awarded: $1,076.15**
Total			**$1,076.15**	**Awarded: $1,076.15**

B. The insurer shall also compute and pay the applicant interest set forth below. 09/10/2019 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).

C. Attorney's Fees

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

Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. See, 11 NYCRR §65-4.5(s)(2) Those fees shall be paid by the insurer. 11 NYCRR §65-4.5(e).

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

08/19/2020
(Dated)

Antonietta Russo

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:
77b4ffa9cb7e9690ff2af6e85bc025e5

Electronically Signed

Your name: Antonietta Russo
Signed on: 08/19/2020