American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

MUA Chiropractic Healthcare, PLLC (Applicant)	AAA Case No.	17-18-1102-9455
	Applicant's File No.	GS-440527
- and -	Insurer's Claim File No.	0393530506 SNM
Allstate Insurance Company (Respondent)	NAIC No.	29688

ARBITRATION AWARD

I, Alana Barran, 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: Patient

1. Hearing(s) held on 09/11/2020
   Declared closed by the arbitrator on 09/11/2020

   Michael Poropat from Law Offices Of Gabriel & Shapiro, LLC. participated for the Applicant

   Christine McGreevy from Law Offices Of Karen L. Lawrence participated for the Respondent

2. The amount claimed in the Arbitration Request, **$ 410.55**, 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 Patient, SD, is a 28 year old male that was involved in an accident on 11/24/15. This is a claim for office visits performed from 1/25/16 through 11/8/16. The Respondent denied the claim for services 11/8/16 and 4/18/16 based on the IME of Dr. Michael Berke; argues that the claim for services 3/21/16 was not received and is not due; and argues that the Applicant failed to provide verification requested related to the claim for services 1/25/16, that the verification response was insufficient, and that the claim is not due. The issues raised are whether the Respondent sustained its defense of lack of medical necessity; whether the claim for services 3/21/16 and 1/25/16 are due.

4. Findings, Conclusions, and Basis Therefor

My decision is based on the arguments of the representatives for both parties and those documents contained in the ADR Center for this case.

IME(DOS11/8/16 and 4/18/16)

The Respondent relied on the IME of Dr. Michael Berke on 3/5/16 in denying the bill for services 11/8/16 and 4/18/16 at issue for lack of medical necessity. Dr. Michael Berke reviewed medical records. His examination revealed normal findings of the cervical spine and thoracolumbar spine. He concluded that the injuries were resolved and that no further treatment was medically necessary. I find the IME of Dr. Michael Berke to be sufficient to meet the Respondent's burden of proof to sustain its defense of lack of medical necessity.

The records in submission include evaluations dated 1/25/16, 3/1/16 without a physical evaluation, 4/18/16 with full ROM, 11/8/16, 12/4/15, 12/7/15; hospital records dated 11/24/15. I find the records in submission to be unpersuasive and sufficient to rebut the findings of the IME doctor.

The applicant has established its initial entitlement to no fault benefits.The burden then shifts to the respondent. The respondent's denial for lack of medical necessity must be supported by a peer review or other competent medical evidence which sets forth a clear factual basis and medical rationale for denying the claim. Healing Hands Chiropractic, P.C. v. National Assurance Co., 5 Misc. 3d 975; Citywide Social Work, et. al v. Travelers Indemnity Co., 3 Misc. 3d 608. The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment,Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 2009 NY Slip Op 00351 (App Div. 2d Dept., Jan. 20, 2009); Channel Chiropractic, P.C. v. Country-Wide Ins. Co., 2007 Slip Op 01973, 38 A.D.3d 294 (1st Dept. 2007); Bronx Radiology, P.C. v. New York Cent. Mut. Fire Ins. Co., 2007 NY Slip Op 27427, 17 Misc.3d 97 (App Term 1st Dept., 2007). Here, the Respondent has met its burden of proof to sustain its defense of lack of medical necessity.

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. Yklik, Inc. v. Geico Ins. Co., 2010 NY Slip Op. 51336(U) (App Term 2d, 11th & 13th Dists. July 22, 2010); High Quality Medical, P.C. v. Mercury Ins. Co., 2010 N.Y. Slip Op. 50447(U) (App Term 2d, 11th & 13th Dists. Mar. 10, 2010); Pan Chiropractic, P.C. v. Mercury Ins. Co.,24 Misc.3d 136(A), 2009 N.Y. Slip Op. 51495(U) (App Term 2d, 11th & 13th Dists. July 9, 2009). Here, I find that the records in submission are insufficient to rebut the findings of the IME doctor.

I find that the IME of Dr. Michael Berkehas met the Respondent's burden of proof to sustain its defense of lack of medical necessity. The burden has shifted to the Applicant and has not been rebutted. Therefore, the claim for services 11/8/16 and 4/18/16 is denied.

Non-Receipt(DOS 3/21/16)

The Respondent argues that the bill for services 3/21/16 in the sum of $95.31 at issue is not overdue as it was not received and a denial has not been issued. The Applicant submits a mailing log with an affidavit of Megan McRae notarized on 5/2/16 to establish mailing of the claim at issue to the Respondent prior to the filing for his arbitration. The mailing log bears no evidence to indicate that the bill for services at issue was actually mailed such as a postal stamp. Furthermore, the affidavit of Ms. McRae states "I, Megan McRae swear under penalty of perjury that on 4/29/16 the above items [which lists the claim at issue] were deposited a post office regularly maintained by the United States Government located at 3300 Park Avenue, Wantagh, NY 11793" without providing a source for her knowledge that the bill was actually mailed, whether she or someone else mailed it. Despite the mailing log listing a priority tracking number, confirmation of the delivery or even acceptance by the post office is not provided, and a simple USPS search of the tracking number does not provide a result.

I find that the relevant credible evidence is insufficient to establish that the bill for services 3/21/16 at issue was timely and properly mailed to the Respondent, that the Applicant has not met its prima facie case, and that the bill is not overdue. Therefore, the claim for services 3/21/16 is dismissed without prejudice.

Pursuant to 11 NYCRR § 65-1.1 "the eligible injured person or that person's assignee … shall submit written proof of claim to the Company … in no event later than 45 days after the date services are rendered"). See SZ Med. P.C. v. Country-Wide Ins. Co., 12 Misc.3d 52, 2006 NY Slip Op 26194 (App Term 2d & 11th Jud. Dists., May 17, 2006).

Section 65-3.8 (a) (1) Payment or denial of claim (30 day rule). states: "No-Fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested pursuant to section 65-3.5 of this subpart."

Verification requested (DOS 1/25/16)

The Respondent relies on verification requests dated 3/21/16 and 4/25/16 related to the claim for services 1/25/16 in the sum of $124.62 and to which it argues that a response was not received, and argues that the bills are not overdue. A denial has not been issued. The Respondent sought paperwork regarding formation, purchase or transfer of business interests including agreements, correspondence, certificate of incorporation; name and address of all entities and documents between the applicant and such entity for the provision of leasing, administrative, management, consulting, accounting, billing; description of the relationship between the applicant and Astoria Chiropractic Services; list of individuals who provided and supervised technical and professional aspects of the services billed; proof that the treating provider was an employee of applicant; letter of medical necessity; copy of surgical consent forms; copy of recovery room records; examination under oath of the patient. There are no issues raised with regard to the letters requesting verification themselves.

The applicant argues that its response dated 4/25/16 objecting to the incorporation and business records, stating that the respondent is prohibited from repeatedly asking for information that has been supplied, stating that "as we have provided copies (which we deem is sufficient cooperation with your requests despite not being obligated to do so, which you deem insufficient, we are not obligated to provide your company with originals of such documents at our expense. Your company is free to do so we have stated this numerous times for various clients. For any verification that has not been provided, we object to the information demanded as unduly burdensome and improper. If you disagree, please provide your basis for requirement."

The Respondent argues that the verification requested is reasonable and outstanding, that the Applicant does not provide any proper response or objection to its request. The applicant argues that it provided a sufficient response on 4/25/16.

I find that the response from the Applicant consisting of a general statement without so much as addressing the individual requests of the Respondent is improper and insufficient to support its position that it substantially responded to the verification requests. I am not persuaded by the Applicant's argument that its response is a sufficient response or a valid objection to each of the specific requests by the Respondent. I find that the Applicant failed to sufficiently respond to the verification requested and that verification remains outstanding. Therefore, I find in favor of the Respondent, and the claim is dismissed without prejudice for the Applicant to respond to the verification requested.

Section 65-3.6 (b) states: "Verification requests. At a minimum, if any requested verifications has not been supplied to the insurer 30 calendar days after the original request, the insurer shall, within 10 calendar days, follow up with the party from whom the verification was requested, either by telephone call, properly documented in the file, or by mail. At the same time the insurer shall inform the applicant and such person's attorney of the reason(s) why the claim is delayed by identifying in writing the missing verification and the party from whom it was requested."

11 NYCRR 65-3.5 (o) indicates: An applicant from whom verification is requested shall, within 120 calendar days from the date of the initial request for verification, submit all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. The insurer shall advise the applicant in the verification request that the insurer may deny the claim if the applicant does not provide within 120 calendar days from the date of the initial request either all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply. 11 NYCRR 65-3.8 (b) (3) indicates that an insurer may issue a denial if, more than 120 calendar days after the initial request for verification, the applicant has not submitted all such verification under the applicant's control or possession or written proof providing reasonable justification for the failure to comply, provided that the verification request so advised the applicant as required in section 65-3.5(o) of this Subpart.

Section 65-3.8 (a) (1) Payment or denial of claim (30 day rule). states: "No-Fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested pursuant to section 65-3.5 of this subpart."

Comparing the relevant evidence presented by both parties against each other and the above referenced standards, based on the foregoing, I find in favor of the Respondent and the claim for services11/8/16 and 4/18/16 is denied; and the claim for services 3/21/16 and 1/25/16 is dismissed without prejudice.

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 DISMISSED without prejudice

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

09/24/2020
(Dated)

Alana Barran

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:
e46edc5648f85842008dedaff93596e3

Electronically Signed

Your name: Alana Barran
Signed on: 09/24/2020