American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

DHD Medical, P.C. (Applicant)	AAA Case No.	17-19-1138-6234
	Applicant's File No.	54424
- and -	Insurer's Claim File No.	1038085-02
	NAIC No.	16616
American Transit Insurance Company (Respondent)		

ARBITRATION AWARD

I, Eileen Hennessy, 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-K.G.

1. Hearing(s) held on 10/27/2020
   Declared closed by the arbitrator on 10/27/2020

   Dayva Zaccaria from Law Office of Gewurz & Zaccaria, PC participated by telephone for the Applicant

   Tina Lin from American Transit Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 361.38**, was NOT AMENDED at the oral hearing.
   Stipulations WERE made by the parties regarding the issues to be determined.

   The parties stipulated and agreed that (i) Applicant has met its prima facie burden by submitting evidence that payment of no-fault benefits is overdue, and proof of its claims were mailed to and received by Respondent; (ii) Respondent's denials of the subject claims were timely issued; and (iii) the amounts claimed do not exceed the maximum permissible charges under the fee schedule applicable to the disputed supplies.

3. Summary of Issues in Dispute

   The record reveals that the Assignor-K.G., a 30-year-old female, claimed injuries as the passenger of a motor vehicle involved in an accident that occurred on 9/2/2018. Applicant seeks reimbursement for office visits and physical therapy conducted from

6/11/2019 through 7/16/2019. Respondent denied the bills based upon the claimant's failure to disclose prior injuries and losses at an Examination under Oath (EUO), thereby constituting non-cooperation with the EUO and a breach of a condition precedent to coverage. Respondent also denied the claim based upon the Independent Medical Examination (IME) of Dr. Michael L. Russ, M.D., effective 1/9/2019. The issues at this hearing are 1) whether Respondent has sustained its burden as to proof of fraud or misrepresentation through failure to disclose prior accidents at an EUO and 2) whether the services are medically necessary?

4. Findings, Conclusions, and Basis Therefor

Applicant seeks reimbursement foroffice visits and physical therapy. 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.

11 NYCRR 65-4.5 (o) (1) (Regulation 68-D), reads as follows: The 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 arbitrator may question any witness or party and independently raise any issue that the arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department Regulations.

FRAUD/MISREPRESENTATION

Respondent denied the bills at issue as follows: "Entire claim is denied based upon the claimant's failure to disclose prior injuries and losses thereby constituting non-cooperation with the examination under oath and a breach of a condition precedent to coverage."

Under 11 NYCRR § 65-1.1 which prescribes the No-Fault Mandatory Personal Injury Protection (PIP) Endorsement, which must be included in all owners' policies of motor vehicle liability insurance issued in New York, the "Conditions" section of the endorsement contains a "Proof of Claim" provision, which states that:

> Upon request by the Company, the eligible injured person or that person's assignee or representative shall:
> (a) execute a written proof of claim under oath;
> (b) as may reasonably be required submit to examinations under oath by any person named by the Company and subscribe the same;
> (c) provide authorization that will enable the Company to obtain medical records; and
> (d) provide any other pertinent information that may assist the Company in determining the amount due and payable.

Pursuant to 11 NYCRR 65-1.1: 'Conditions', "Upon request by the Company, the eligible injured person or that person's assignee or representative shall … (d) provide any other pertinent information that may assist the Company in determining the amount due and payable."

The Proof of Claim subsection to the Section, Conditions, contained in the prescribed endorsement, refers to EUO requested "as may reasonably be required". The right to an EUO is further proscribed by 11 NYCRR § 65-3.2; Claim practice principles to be followed by all insurers, which reads:

> (a) Have as your basic goal the prompt and fair payment to all automobile accident victims.
> (b) Assist the applicant in the processing of a claim. Do not treat the applicant as an adversary.
> (c) Do not demand verification of facts unless there are good reasons to do so. When verification of facts is necessary, it should be done as expeditiously as possible.
> …
> (e) Clearly inform the applicant of the insurer's position regarding any disputed matter.

Once the Injured Party establishes its prima facie case, there is a presumption of coverage and the burden of going forward (burden of production) falls on the insurer to prove that it had a founded belief that there was a staged accident. *See* Mount Sinai Hosp. v. Triboro Coach, 263 A.D. 2d 11, 19-20 (2nd Dept., 1999), *citing* Central General Hospital v. Chubb Group of Ins. Co.'s, 90 NY 2d 195, 199, 681 NE 2d 413, 659 NYS 2d 246. An insurer's "founded belief" cannot be based upon "unsubstantiated hypotheses and suppositions." A.B. Med Services PLLC v. Eagle Ins. Co., 3 Misc 3d 8, 9 (App. Term 2d Dept, 2003); and must be established by a preponderance of the evidence. V.S. Medical Services, P.C., v. Allstate, 25 Misc. 3d 39, 889 NYS 2d 360, (App Term 2nd Dept., 2009).

In support of its defense, Respondent has attached the EUO transcript of the Assignor and an ISO Claim Search. This ISO report appears to list a 4/27/2018 accident in which the Assignor was involved and according to the report sustained injuries to her neck, back, and knee. The report further indicates the Assignor received multi-modality treatment with several no-fault clinics.

It is undisputed that the EUO of the Assignor took place on 3/19/2019. Respondent's attorney argued that the Assignor was uncooperative because she failed to testify about an accident occurring on 4/27/2018 that was listed in the ISO report. She argued that beginning on page 9 of the EUO transcript, the examiner questioned the Assignor about other accidents, which she denied. Thus, Respondent's attorney argued that the Assignor concealed the 4/27/2018 accident and therefore was uncooperative. Specifically, the Assignor's testimony included the following at page 9 of the transcript:

Q. Were you ever involved in a past motor vehicle accident?

A. No.

Q. Have you been involved in a motor vehicle accident after 9/2/2018?

A. No.

Applicant submits an affidavit of Assignor-K.G., dated 9/24/2020, wherein she states that she fully cooperated with the EUO by answering every question posed truthfully. She acknowledged that she testified that she was not involved in any prior accidents. She further stated "The was an accident involving my vehicle on 4/27/18,however, I was not in the vehicle at the time of the accident. Therefore, when I was asked if I was involved in a past motor vehicle accident, I answered truthfully, that I was not".

Applicant's attorney further argued that the ISO search was not supported by an affidavit explaining the information and that it does not prove anything. She further argued that a review of the EUO transcript shows that the Assignor was cooperative during the EUO, answering all of the questions. Hence, she argued that the Respondent failed to establish its defense of a lack of cooperation.

In sum, Respondent is alleging fraud or a material misrepresentation. Respondent alleges that the Assignor suppressed information by failing to disclose that the Assignor was involved in this prior accident. While it's clear that Respondent was entitled to receive the information regarding the 4/27/2018 incident, the question is whether it proved that the Assignor failed to cooperate in its investigation into that incident. After a review of all the evidence, I find Respondent has not sustained its burden of proof. From this arbitrator's review of the transcript, Respondent's counsel failed to directly ask a question as to this specific 4/27/2018 prior motor vehicle accident.

I find that in the decision *Optimus Plus Products Corp and A. Central Insurance Company*, AAA Case No. 17-18-1090-1864, my esteemed colleague, Arbitrator Michelle Entin, Esq., set forth the proper analysis for determining whether a claimant failed to cooperate with an insurer's investigation. She stated:

> The First Department has held an Assignor's failure to comply with a carrier's repeated requests for 'statements', warranted the dismissal of an action sustaining a denial of no-fault benefits (*See* IK Med., P.C. v. Travelers Prop. Cas. Ins. Co., 13 Misc. 3d 128(A), citing 11 NYCRR 65-1.1[d]). However, courts impose a heavy burden on insurance companies disclaiming coverage for an insured's failure to cooperate (*See* Thrasher v. United States Liab. Ins. Co., 19 NY2d 159). The insurer must (1) demonstrate that it acted diligently in seeking to bring about the insured's cooperation; (2) the efforts employed by the insurer were reasonably calculated to obtain the insured's cooperation; and (3) that the attitude of the insured, after his cooperation was sought, was one of "willful and avowed obstruction" (*See* N.Y. Central Mutual Fire Ins. Co. v. Salomon, 11 AD 3d 315, citing Thrasher. The Salomon court further

> cited the Court of Appeals, in Matter of Empire Mut. Ins. Co. [Stroud], 36 N.Y. 2d 719, 721-722 (1975), for the proposition that "[m]ere inaction by the insured is not enough.

Applying the above standard to the facts of this case, I find that Respondent failed to establish that the Assignor did not cooperate during the EUO. A review of the EUO transcript reveals that the Assignor was forthcoming with information about the current accident, as well as regarding facts about her conditions and the medical treatment she received due to the accident. Further, Assignor-K.G. states under the penalties of perjury in the affidavit that, while her vehicle was involved in the accident on 4/27/2018, she was not in the vehicle at the time of the loss, thereby explaining her response. It is also noted Respondent's attorney conducting the EUO never attempted to obtain additional information regarding the 4/27/2018 incident. Respondent claims that the Assignor's answers constituted "non-cooperation"; however, the Assignor answered every question posed to her. Respondent's counsel at the EUO never specifically inquired about the alleged 4/27/2018 prior accident, despite the carrier's supposed knowledge of the same. A proper follow up question was warranted. According to 11 NYCRR § 65-3.2; Claim practice principles to be followed by all insurers, Respondent has a duty to: (b) Assist the applicant in the processing of a claim. Do not treat the applicant as an adversary and (e) Clearly inform the applicant of the insurer's position regarding any disputed matter. If the Respondent believed the Assignor was involved in other motor vehicle accidents, they had a duty to seek further information in a direct manner.

Thus, I find that Respondent was not diligent in attempting to obtain information regarding that incident and the EUO questioning was not reasonably calculated to obtain that information or the Assignor's cooperation. Also, I find that Respondent failed to demonstrate that the omission was willful or even an omission (given that, according to the Assignor's affidavit, the incident may have involved the Assignor's vehicle but not the Assignor).

In addition, Respondent has simply attached an ISO Claim Search without any affidavit from an expert explaining how to read the document. No SIU affidavit was included in the submissions. Respondent would have been better served by more direct and specific questioning of prior motor vehicle accidents as well as an affidavit clearly establishing said prior accidents.

Even if one were to assume that the Assignor failed to mention this prior accident, it is not automatically assumed that this would rise to the level of "material" misrepresentation or fraud.

Even by a standard of a preponderance of the evidence, Respondent failed to meet its burden of proof in establishing its defense that the Assignor failed to cooperate with the Respondent's EUO and/or investigation.

Legal Standards for Determining Medical Necessity

Once applicant has established a prima facie case, the burden then shifts to respondent to establish a lack of medical necessity with respect to the benefits sought. *See*, Citywide

Social Work & Psychological Services, PLLC v. Allstate Ins. Co., 8 Misc3d 1025A (2005). A denial premised on lack of medical necessity must be supported by competent evidence such as an IME, peer review or other proof which sets forth a factual basis and medical rational for denying the claim. *See*, Healing Hands Chiropractic, P.C. v. Nationwide Assur. Co., 5 Misc3d 975 (2004).

In evaluating the medical necessity of services with proof of each party, particularly where the conclusion is contradictory; consideration must be given to the evidentiary burdens. Respondent must prove first that the services were not medically necessary. The issue of whether treatment is medically unnecessary cannot be resolved without resort to meaningful medical assessment. Kingsborough Jewish Med. Ctr. v. All State 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 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). Where the defendant insurer presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden shifts to the plaintiff which must then present its own evidence of medical necessity. West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 4(App. Term 2d & 11th Dists. Sept. 29, 2006). For an applicant to prove that the disputed expense was medically necessary, it must meaningfully refer to, or rebut, respondent's evidence. *See*, Yklik, Inc. v. Geico Ins. Co., 28 Misc3d 133A (2010). The case law is clear that a provider must rebut the conclusions and determinations of the IME doctor with his own facts. Moreover, the Appellate Term, 2d, 11th & 13th Dists., stated: "Assuming the insurer is successful in satisfying its burden, it is ultimately plaintiff who must prove, by a preponderance of the evidence, that the services or supplies were medically necessary." Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co., 37 Misc.3d 19, 22 (App. Term 2d, 11th & 13th Dists. 2012). 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, as the ultimate burden of proof on the issue of medical necessity lies with the claimant. *See* Insurance Law § 5102; AJS Chiropractic, P.C. v. Mercury Ins. Co., 22 Misc.3d 133(A), (App. Term 2d & 11th Dist. Feb. 9, 2002); Wagner v. Baird, 208 A.D.2d 1087 (3d Dept. 1994).

Application of Legal Standards

I note the validity of denials based upon negative IME findings have been recognized by several Courts. *See e.g.* Innovative Chiropractics P.C. v. Mercury Ins. Co., 25 Misc3d 137 (App. Term 2d & 11th Dists. 2009); B.Y. M.D., P.C. v. Progressive Casualty Ins. Co., 26 Misc3d 125 (App. Term 9th & 10th Dists. 2010). An IME report can be the basis of a termination of benefits if ultimately found to be persuasive. Whether an IME report is persuasive, and meets the carrier's burden is a factual decision, which must be rendered on a case by case basis. Therefore, when, as here, an insurer interposes a timely denial of claim that sets forth a sufficiently detailed factual basis and adequate medical rationale for the claim's rejection, the presumption of medical necessity and causality attached to the applicant's properly completed claim is rebutted and the burden shifts back to the claimant to refute the IME findings and prove the necessity of the disputed

services and the causal relationship between the injuries and the accident. *See*, CPT Med. Servs., P.C. v. New York Cent. Mut. Fire Ins. Co., 18 Misc.3d 87 (App. Term 1st Dept.); A.Khodadadi Radiology, P.C. v. NY Cent. Mut. Fire Ins. Co., 16 Misc. 3d. 131 (A) (App Term 2d Dept.).

In support of its contention that further treatment was not medically necessary, Respondent relies upon the Physical Medicine and Rehabilitation (PMR) and acupuncture examination report of Dr. Michael L. Russ., M.D.,conducted on 12/12/2018. The PMR examination is relevant to the bills in dispute and will be discussed herein. The Assignor had present complaints of pain in the neck, mid-back, and lower back that radiates to the right leg with numbness and pain in the right knee. Dr. Russ noted minimal tenderness in the cervical, thoracic, and lumbar spine. The examination reveals all tests were objectively negative and unremarkable. Range of motion was full. Motor strength of the upper and lower extremities was 5/5. Sensory examination of the upper and lower extremities was normal. Dr. Russ diagnosed resolved cervical, thoracic, and lumbar spine and right knee sprains. From a PMR viewpoint, there was no need for any further treatment, including physical therapy. From the details of the subjective symptoms, Dr. Russ recommend a home exercise and stretching program. Based upon Dr. Russ's examination all PMR and acupuncture No-fault benefits were denied effective 1/19/2019.

In this matter, I am faced with conflicting opinions concerning the medical necessity for the treatment. There are no legal issues to resolve. This dispute involves solely an issue of fact, that is, whether the services billed was medically necessary. Resolution of that fact is determined by which opinion is accepted by the trier of fact.

I find the report for the IME conducted by Michael L. Russ, M.D.on 12/12/2018 to be sufficient for the purpose of establishing Respondent's defense. The report adequately sets forth the factual basis and medical rationale to support the conclusion that the Assignor was not in need of any further treatment. That being so, the burden shifts to the Applicant to counter Respondent's showing.

While the report for the IME conducted by Dr. Russ is sufficient to establish Respondent's defense, after comparing the relevant evidence presented by both parties, and upon consideration of the arguments of counsel, the evidence submitted by the Applicant persuades me to find as a matter of fact that the Assignor's injuries had yet to resolve and that she was in need of continued PMR treatment. My decision accounts for the Assignor's subjective complaints of pain and positive objective findings documented in the contemporaneous examinations by Shouhei Yamagami, D.O. and Thomas S. Matthew, M.D., dated 11/28/2018, 1/22/2019, and 1/23/2019. The findings in these reports coupled with the cervical spine MRI report, dated 12/5/2018, EMG/NCV test results, dated 3/20/2019, and physical therapy progress notes are sufficient to rebut the findings in the IME report. I find that Applicant was able to adequately rebut the conclusions of Dr. Russ' IME. Applicant's evidence is more persuasive. Therefore, Applicant's claims denied premised upon the IME of Dr. Russ are granted.

CONCLUSION

Accordingly, Applicant's claim is granted in its entirety. 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**
	DHD Medical, P.C.	**06/11/19 - 07/16/19**	**$361.38**	**Awarded: $361.38**
Total			**$361.38**	**Awarded: $361.38**

B. The insurer shall also compute and pay the applicant interest set forth below. 08/16/2019 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 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, interest shall accrue from 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

Applicant is entitled to an attorney's fee pursuant to Insurance Law §5106(a). After calculating the sum total of the first-party (No-Fault) benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, subject to the following limitations: In the event the above filing date was prior to Feb. 4, 2015, the attorney's fee is subject to a minimum of $60.00 and a maximum of $850.00, per 11 NYCRR 65-4.6(e). In the event the above filing date was on or after Feb. 4, 2015, the attorney's fee is subject to a maximum of $1,360.00, per 11 NYCRR 65-4.6(d). In the event the above filing date was on or after Feb. 4, 2015 and first-party (No-Fault) benefits are awarded to more than one Applicant herein, the attorney's fee shall be calculated separately for each Applicant, each Applicant's attorney fee being subject to the $1,360.00 maximum.

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

11/27/2020
(Dated)

Eileen Hennessy

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
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Electronically Signed

Your name: Eileen Hennessy
Signed on: 11/27/2020