American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Surgicare Surgical Associates of Mahwah (Applicant)	AAA Case No.	17-20-1154-3620
	Applicant's File No.	SCMA-GNY-BXNY-018
- and -	Insurer's Claim File No.	0486838560101021
	NAIC No.	22055
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Bernadette Connor, 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 12/17/2020
   Declared closed by the arbitrator on 12/17/2020

   David Quinones Jr., Esq. from Callagy Law, PC participated by telephone for the Applicant

   Eric Schechner, Claims Representative from Geico Insurance Company participated by telephone for the Respondent

2. The amount claimed in the Arbitration Request, **$ 1,458.76**, 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

   This claim arises out of a motor vehicle accident that occurred on September 18, 2019. The Assignor, a 49-year-old male, sustained injuries to the neck, back, and right shoulder. Applicant seeks a facility fee for lumbar medial branch block injections performed on November 13, 2019. Respondent denied payment based on a report dated December 4, 2019, by Jason R. Cohen, M.D.

   The issue presented is whether the services provided to the Assignor herein were medically necessary.

4. Findings, Conclusions, and Basis Therefor

I have carefully reviewed the submissions contained in the Modria ADR Center maintained by the American Arbitration Association. I have also considered the oral arguments of the parties presented at the hearing of this matter.

An arbitrator "shall be the judge of the relevance and the materiality of the evidence offered, strict conformity to the rules of evidence shall not be necessary. The arbitrator may question or examine any witness or party and independently raise any issue that arbitrator deems relevant to making an award that is consistent with the Insurance Law and Department regulations." 11 N.Y.C.R.R. 65-45 (o) (1). Additionally, as the trier of the facts and the law, an Arbitrator is authorized to review and take judicial notice of any rule, law, medical document or periodical or any other document which may impact and aid in making a decision, as long as it conforms to the Insurance laws and the New York State Insurance Department Regulations. *Matter of Medical Society v. Serio,* 100 NY2d 854, 768 NYS2d 423 (2003).

At the outset of the hearing of this matter, Applicant raised a preliminary issue regarding the preclusion of Dr. Cohen's report. Applicant did not submit a rebuttal to Dr. Cohen's report. Instead, Applicant argued that the report should be precluded as Respondent failed to provide Applicant with the documents Dr. Cohen relied upon in reaching the conclusion that the services rendered to the Assignor were not medically necessary, despite Applicant's request for such documents.

Discovery is limited and the rules of evidence are relaxed in the arbitration forum. Pursuant to 11 NYCRR 65-4.4(e), the arbitrator shall be the judge of the relevancy and materiality of the evidence offered and strict conformity to legal rules of evidence shall not be necessary.

In AAA Case Number 412012095264, Arbitrator Tali Philipson addressed this issue:

"The availability of disclosure devices is a significant differentiating factor between judicial and arbitration proceedings; it is contemplated that disclosure devices will be sparingly used in arbitration. DeSapio v. Kohlmeyer, 35 N.Y.2d 402, 406, 362 N.Y.S.2d 843, 847 (1974). Arbitrators do not have the power to direct that parties engage in disclosure proceedings, and only under exceptional circumstances will a court order disclosure in arbitration. Kahn v. New York Times Co., 122 A.D.2d 655, 663, 503 N.Y.S.2d 561, 566 (1st Dept. 1986). Where a dispute has been submitted to arbitration, a party may obtain disclosure only by court order. State Farm Mut. Auto Ins. Co. v. Wernick, 90 A.D.2d 519, 455 N.Y.S.2d 30 (2d Dept. 1982).

Neither the No-Fault regulations promulgated by the Superintendent of Insurance nor the rules of the American Arbitration Association provide for disclosure and inspection akin to that in an action at law. Requiring Arbitrators to engage in discovery disputes

would be contrary to the intent behind the arbitration process which is to provide for the prompt resolution of No-Fault disputes. Certainly, Applicants availing themselves of the arbitration forum are aware of these relaxed rules.

Furthermore, once arbitration gets underway, its conduct is not governed by the substantive or evidentiary rules which commonly prevail in courts of law; rather, the constraints on the arbitral authority are those measured by the bounds of rationality. *Matter of Board of Education of Norwood-Norfolk Central School District v. Hess, 49 N.Y.2d 145, 152, 424 N.Y.S.2d 389, 391 (1979).*

Thus, the majority of Arbitration cases in this forum rest upon hearsay evidence submitted by both Applicants and Respondents alike. Once again, a strict adherence to the rules of evidence would undermine the public policy of guiding No-Fault arbitration, i.e the swift resolution of No-Fault disputes."

I concur with Arbitrator Philipson's well-reasoned decision and adopt the same rationale in this matter. Therefore, Applicant's request to preclude Dr. Cohen's report is hereby denied.

Medical Necessity:

Applicant has established a prima facie entitlement to judgment as a matter of law by proof that it submitted a claim, setting forth the fact and amount of the loss sustained, and that the payment of No-Fault benefits was overdue. See *Viviane Etienne Med. Care v. Country-Wide Ins. Co.,* 25 NY3d 498 (2015); *Westchester Med. Ctr. v. Progressive Cas. Ins. Co.,* 89 AD3d 1081, 933 NYS2d 719, 2011 NY Slip Op. 8747 (N.Y. App. Div. 2d Dept. 2011); *New York Hosp. Med. Ctr. of Queens v. QBE Ins. Corp.,* 114 AD3d 648, 979 NYS2d 694, 2014 NY Slip Op 639 (NY App. Div. 2d Dept. 2014).

Once Applicant establishes a prima facie case of medical necessity, the burden shifts, and Respondent must then produce 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.

A report relied upon by an insurer to defend its denial for No-Fault benefits must demonstrate that the services rendered were not in agreement with generally accepted medical/professional practice. *Jacob Nir, M.D. Assignee of Josapphat Etienne v. Allstate Insurance Co., 796 N.Y.S2 857.* "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." *Citywide Social Work & Psy. Serv. P.L.L.C. v. Travelers Indemnity Co., 3 Misc. 3d. 608, 777 N.Y.S. 2d 241, 2004 NY Slip Op 20034 NY Slip Op 24034 [Civ. Ct. Kings County 2004].*

Jason R. Cohen, M.D. reviewed the medical records and concluded that the medial branch nerve blocks and all associated services performed on November 13, 2019 deviated from the standard protocol. He noted that the records documented radiating lumbar spine pain throughout the right lower extremity in a radicular pattern. There was

also positive straight leg raise testing on examination. Dr. Cohen maintained that these findings are inconsistent and incompatible with facet mediated pain/pathology necessitating lumbar medial branch nerve blocks. Therefore, according to Dr. Cohen, the services were not medically necessary.

I find that Dr. Cohen had forth a sufficient factual basis and medical rationale to support his opinion that the lumbar medial branch nerve blocks and all associated services provided to the Assignor on November 13, 2019 were not medically necessary. Therefore, Respondent has successfully rebutted Applicant's prima facie case of medical necessity. See, *Exclusive Med. Supply, Inc. v Mercury Ins. Group,* 2009 52273 (U) (Appellant Term 2d Dept., Nov. 5, 2009); *Delta Diagnostic Radiology, P.C. v. Progressive Casualty Ins. Co.*, 2008 Slip Op 52450 (U), 21 Misc. 3d 142 (A) (App Term 2d Dept., 2008).

The burden now shifts back to Applicant to refute Dr. Cohen's report and demonstrate the necessity of the services at issue. *CPT Med Services, P.C. v. New York Cent. Mut. Fire Ins. Co.*, 2007 New York Slip Op 27526, 18 Misc. 3d 87 (App Term 1st Dept.); *Eden Med., P.C. v. Progressive Cas. Ins. Co.*, 2008 NY Slip Op 51098 (U), 19 Misc.3d 143 (A) (App Term 2nd & 11th Jud Dists., 2008); *Bath Med. Supply, Inc. v. New York Cent. Mut. Fire Ins. Co.*, 2008 NY Slip Op 50347 (U) (App Term 2d Dept., Feb. 26, 2008; *Khodadadi Radiology v. New York Central,* 16 Misc. 3d 131 (A) (2007).

After carefully reviewing the evidence presented, I find that Applicant has failed to meet its shifted burden of proof. Applicant did not submit a specific report in rebuttal to Dr. Cohen's report. The medical records contained in the file are insufficient to refute Dr. Cohen's credible and persuasive report.

Accordingly, Applicant's claim for a facility fee is denied.

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 DENIED in its entirety

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of New York
SS :
County of New York

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

01/18/2021
(Dated)

Bernadette Connor

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:
7434349b512de071fcb0cd0701f8c1cd

Electronically Signed

Your name: Bernadette Connor
Signed on: 01/18/2021