American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Neighborhood Medical Health Care PC (Applicant)	AAA Case No.	17-19-1116-8459
	Applicant's File No.	GS-696730
- and -	Insurer's Claim File No.	9SINY03356-02
	NAIC No.	29742
Integon National Insurance Company (Respondent)		

ARBITRATION AWARD

I, Kate Cifarelli, 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 03/22/2021
   Declared closed by the arbitrator on 03/22/2021

   Joseph Padrucco, Esq. from Law Offices Of Gabriel & Shapiro, LLC. participated for the Applicant

   John Rossillo, Esq. from Rossillo & Licata LLP participated for the Respondent

2. The amount claimed in the Arbitration Request, **$ 5,339.04**, was AMENDED and permitted by the arbitrator at the oral hearing.

   Applicant amended the amount in dispute to $4,817.76, withdrawing the bill for dates of service 4/10/18-4/30/18 to reflect Respondent's full payment.

   Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

   The Assignor, BD, was a 45 year old female passenger involved in a motor vehicle accident on 3/18/18. Applicant is making a claim for reimbursement for services provided on 4/03/18-5/21/18. Respondent denied the bill for date of service 5/02/18 pursuant to a peer review report prepared by Jay Wiess, M.D. on 7/02/18. For the remaining bills in issue, Respondent alleges that the bills were never received.

4. Findings, Conclusions, and Basis Therefor

Medical Necessity

Peer Review by Jay Weiss, M.D.

Dr. Weiss reviewed the Assignor's medical records and concluded that the range of motion and manual muscle testing were not medically necessary. Standard testing on examination is sufficient and there was no indication that the computerized testing would alter treatment. Further, there were no findings on physical examination to demonstrate weakness that would warrant the computerized testing.

Rebuttal by Kenneth Shapiro, M.D.

Dr. Shapiro prepared a rebuttal setting forth the benefits of computerized range of motion and muscle testing and noted that the testing was warranted in this instance as the Assignor had undergone conservative care without maximum improvement.

Addendum by Jay Weiss, M.D.

Dr. Weiss prepared an addendum to the rebuttal and in further support of his peer review report confirming his conclusions that the computerized testing was not medically necessary.

Arguments at the Hearing

Respondent relied upon the peer review report by Dr. Weiss. Applicant argued that Respondent did not meet its burden as the medical literature relied upon by Dr. Weiss is not sufficient. The sources relied upon are not adequate No Fault sources and are older editions.

In response Respondent first noted that Dr. Weiss is certified in three different specialties and, in addition to relying on voluminous medical literature, relied upon on his own experience to analyze the medical records. Respondent further argued that, just because an older version of certain literature is relied upon, does not mean it is not the most up-to-date standard.

Applicant then argued that, if Respondent met its burden, the rebuttal was sufficient to refute the findings in the peer. Dr. Shapiro sufficiently established that the computerized range of motion is more beneficial than manual range of motion and gives the treating physician an opportunity to gauge the Assignor's progress.

Respondent argued that the rebuttal does not shift the burden back as the statements made by Dr. Shapira are general statements about computerized testing and does not discuss how it would apply to the Assignor. Manual range of motion testing was

performed just two days prior to the computerized testing and a treatment plan was created based upon the manual examination. There is no indication that the treatment plan would change as a result of the computerized testing.

Respondent moreover argued that, if the rebuttal did shift the burden back, the addendum adequately discusses the rebuttal and notes that the treating physician did not even review the follow-up examination confirming that the computerized range of motion testing did not alter the treatment plan.

Medical Necessity

Both parties stipulated to Applicant's *prima facie* case. It is Respondent's burden to establish a lack of medical necessity with competent medical evidence which sets forth a clear factual basis and medical rationale for denying the claim. Citywide Social Work and Psych Services, PLLC v. Allstate, 8 Misc. 3d 1025A (2005); Healing Hands Chiropractic v. Nationwide Assurance Co., 5 Misc. 3d 975 (2004).

Medically necessary treatments or services are "treatments or services which are appropriate, suitable, proper and conducive to the end sought by the professional health service in consultation with the patient. It means more than merely convenient or useful treatments or services, but treatments or services that are reasonable in light of the patient's injury, subjective and objective evidence of the patient's complaints of pain and the goals of evaluation and treating the patient." Fifth Avenue Pain Control Center v. Allstate Ins Co, 196 Misc. 2d 801 (Civ. Ct Queens 2003).

A peer or independent medical examination report must set forth a factual basis to establish the absence of medical necessity. See Nir v Allstate Ins. Co., 7 Misc. 3d. 544, 547 (Civ. Ct., Kings Co., 2005) which indicates that a peer or independent medical examination report defending a denial of first-party benefits on the ground that the billed-for services were not "medically necessary" must at least show that the services were inconsistent with generally accepted medical and professional practice.

Therefore an opinion offered by a Respondent is more likely to establish a lack of medical necessity when it provides a reference to the standards in the applicable medical community for the services and treatment at issue with an explanation as to when such services and treatment would be medically appropriate with objective criteria and an explanation why it was not medically necessary in this case. A medical opinion offered by Respondent that fails to address the accepted medical and professional practices will be viewed with less weight than one that does. See Mitrovic v. Silverman, 104 AD3d 430 (1st Dept, 2013).

I find that the Peer Review provided a sufficient factual basis and medical rationale to support Respondent's defense. The burden shifts back to Applicant to provide sufficient proof to refute the conclusions in the Peer Review report. Yklik, Inc. v. GEICO Ins. Co., 2010 NY Slip Op 51336(U) [28 Misc3d 133(A)] App. Term 2d Dept. (2010).

Applicant cannot meet its burden. I do not find the rebuttal or supporting medical records sufficient to refute the findings in the peer review report. Even if it did I find

that the addendum adequately addressed each point made in the rebuttal and the medical records.

Applicant's claim for reimbursement for date of service 5/02/18 is DENIED.

Bills Not Received

Respondent argued that the remaining bills in issue were never received.

Proof of Claim; Medical, Work Loss, and Other Necessary Expenses. In the case of a claim for health service expenses, the eligible injured person or that person's assignee or representative shall submit written proof of claim to the Company, including full particulars of the nature and extent of the injuries and treatment received and contemplated, as soon as reasonably practicable but, in no event later than 45 days after the date services are rendered…

It is Applicant's *prima facie* obligation to establish its entitlement to payment for each service for which reimbursement is sought. It is well settled that a health care provider establishes its *prima facie* entitlement to payment as a matter of law by proof that it submitted a proper claim, setting forth the fact and the amount charged for the services rendered and that payment of no-fault benefits was overdue. Insurance Law §5106 a; Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD 3d 742, 774N.Y.S. 2d 564 (2004); Amaze Med. Supply v. Eagle Ins. Co., 2 Misc. 3d 128A, 784 N.Y.S. 2d 918, 2003 NY Slip Op 51701U (App Term. 2 & 11 Jud Dists).

Applicant submitted Proof of Mailing demonstrating that the bills were sent to National Liability & Fire Insurance Company, P.O. Box 113247, Stamford, CT 06911-3247. Respondent argued that this is not a proper address for Respondent as evidenced by the bills and NF-10 setting forth an address of Integon National Insurance Company c/o Assigned Risk Solutions, P.O. Box 9028, Bethpage, New York 11714.

In response, Applicant argued that the bill that was paid by Respondent was also sent to the Stamford, CT address and therefore it is evidence that Respondent received and processed mail at that address. Respondent argued that payment of a bill is not evidence that it was the proper address.

Respondent met its burden. The address on the Proof of Mailing is not consistent with the address indicated on the bill or NF-10. The company name of Respondent is also not consistent. Applicant was able to establish how it obtained the Stamford, CT address when the bills list the Bethpage, NY address.

I am not persuaded by Applicant's argument that, just because one bill was paid and/or denied, that establishes that Stamford, CT is the proper address.

Applicant's claims for the following bills are DISMISSED WITHOUT PREJUDICE:

- **Date of Service 4/03/18-4/17/18 in the amount of $386.08;**

- **Date of Service 4/30/18 in the amount of $204.41;**

- **Date of Service 4/30/18 in the amount of $92.97;**

- **Date of Service 5/16/18 in the amount of $249.96;**

- **Date of Service 5/21/18 in the amount of $3119.44; and**

- **Date of Service 5/21/18 in the amount of $181.22.**

The case was decided on the submissions of the Parties as contained in the ADR Center maintained by the American Arbitration Association and the oral arguments of the parties' representatives. There were no witnesses. I reviewed the documents contained in the ADR Center for both parties and make my decision in reliance thereon.

Any further issues raised in the submissions of the Parties as contained in the ADR Center maintained by the American Arbitration Association are held to be moot and/or waived insofar as not raised at the time of the hearing.

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**	**Amount Amended**	**Status**

	Neighborhood Medical Health Care PC	**04/03/18 - 04/17/18**	**$386.08**		**Dismissed without prejudice**
	Neighborhood Medical Health Care PC	**04/10/18 - 04/30/18**	**$521.28**		**Withdrawn with prejudice**
	Neighborhood Medical Health Care PC	**05/02/18 - 05/02/18**	**$583.68**		**Denied**
	Neighborhood Medical Health Care PC	**04/30/18 - 04/30/18**	**$204.41**		**Dismissed without prejudice**
	Neighborhood Medical Health Care PC	**04/30/18 - 04/30/18**	**$92.97**		**Dismissed without prejudice**
	Neighborhood Medical Health Care PC	**05/21/18 - 05/21/18**	**$3,119.44**		**Dismissed without prejudice**
	Neighborhood Medical Health Care PC	**05/21/18 - 05/21/18**	**$181.22**		**Dismissed without prejudice**
	Neighborhood Medical Health Care PC	**05/16/18 - 05/16/18**	**$249.96**		**Dismissed without prejudice**

Total	**$5,339.04**		**Awarded: $0.00**

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

03/24/2021
(Dated)

Kate Cifarelli

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:
a925ca0e28c8dd130e51776a4a030a9d

Electronically Signed

Your name: Kate Cifarelli
Signed on: 03/24/2021