

American Arbitration Association  
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Acupuncture Natural Wellness LLC , Touch Stone Chiropractic P.C. (Applicant)	AAA Case No.	17-19-1136-4501
	Applicant's File No.	none
	Insurer's Claim File No.	0108431890101023
- and -	NAIC No.	22055

Geico Insurance Company  
(Respondent)

**ARBITRATION AWARD**

I, Thomas Eck, 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 03/31/2021  
Declared closed by the arbitrator on 04/05/2021

Roman Kulik from Kulik Law Firm, PC participated in person for the Applicant

Jaime Drantch from Geico Insurance Company participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **\$ 1,359.36**, 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 arbitration arises out of medical treatment for the Assignor, a 19-year-old male, related to injuries sustained in a motor vehicle accident that occurred on 3/5/2019. Applicant seeks reimbursement for evaluation, chiropractic care, and EMG/NCV of the lower extremities provided to the Assignor on 3/20/2019-4/24/2019. Respondent paid/denied these services based on the Workers' Compensation Fee Schedule and peer review conducted by Dr. Eric Littman, DC, dated 5/21/2019. Applicant has submitted the rebuttal by Dr. Angelo Dimaggio, DC, dated 7/15/2019. Respondent has submitted an addendum by Dr. Littman, dated 9/11/2019.

#### 4. Findings, Conclusions, and Basis Therefor

This case was decided on the submissions of the parties as contained in the Electronic Case Folder (ECF) maintained by the American Arbitration Association and the oral arguments of the parties' representatives at the hearing. No witnesses testified at the hearing. I reviewed the documents contained in the ECF for both parties and make my decision in reliance thereon.

#### **FEE SCHEDULE - Bill for DOS 3/20/2019-3/27/2019 - Amount in Dispute - \$104.04**

An insurance carrier's timely asserted defense that the bills submitted were not properly No-Fault rated or that the fees charged were in excess of the Workers' Compensation fee schedule is sufficient, if proven, to justify a reduction in payment or denial of a claim. East Coast Acupuncture, P.C. v. New York Cent. Mut. Ins., 2008 NY Slip Op 50344(U) (App. Term 2d Dep't., Feb. 21, 2008).

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defenses. See, Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co., 2006 NY Slip 26240, 13 Misc.3d 172, 822 N.Y.S.2d 378, 2006. If Respondent fails to demonstrate by competent evidentiary proof that an Applicant's claims were in excess of the appropriate fee schedules, Respondent's defense of noncompliance with the appropriate fee schedules cannot be sustained. See, Continental Medical PC v. Travelers Indemnity Co., 11 Misc.3d 145A, 819 N.Y.S.2d 847, 2006 NY Slip Op 50841U, 2006 N.Y. Misc. LEXIS 1109 (App. Term, 1st Dep't, per curium, 2006).

Defenses based on the fee schedule can be raised at any time as per the Fourth Amendment to 11 NYCRR 65-3/Insurance Regulation 68-C). The new sections apply to any treatment or service rendered on or after April 1, 2013. Based on 11 NYCRR 3.8(g)(1)(ii). "The purpose of the [no-fault] statute and the fee schedules promulgated thereunder is to significantly reduce the amount paid by insurers for medical services, and thereby help contain the no-fault premium." Saddle Brook Surgicenter, LLC v. All State Ins. Co., 48 Misc.3d 336, 8 N.Y.S.3d 875 (Civ. Ct. Bronx Co. 2015).

I take judicial notice of the New York State Workers' Compensation Board Medical Fee Schedule ("Fee Schedule") because it is of sufficient authenticity and reliability. See, Kingsbrook Jewish Med. Ctr. v. Allstate Ins. Co., 61 A.D.3d 13, 871 N.Y.S.2d 680 (2d Dept. 2009); LVOV Acupuncture, P.C. v. Geico Ins. Co., 32 Misc.3d 144(A), 939 N.Y.S.2d 741(Table) (App Term 2d, 11th & 13th Jud Dists. 2011).

Code 98941

Applicant submitted a bill for services under CPT codes 98941 for each DOS. Respondent has not submitted any evidence to establish why they did not reimburse the Applicant for the services performed under CPT code 98941. A review of the fee schedule shows the correct reimbursement for services performed under code 98941 is \$34.68 (5.78 x 6). Therefore, I find in favor of the Applicant and hereby award **\$104.04** (\$34.68 x 3).

**MEDICAL NECESSITY - DOS 4/24/2019 - Amt in Dispute \$1102.56 - Codes 99212, 95903, 95934, 95861, 95904**

Applicant has established its prima facie case with 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 (see Insurance Law § 5106 a; Mary Immaculate Hosp. v. Allstate Ins. Co., 5 AD 3d 742, 774 N.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, 2d & 11th Jud Dists]). The burden shifts to the insurer to prove that the services were not medically necessary.

If an insurer asserts that the medical test, treatment, supply or other service was medically unnecessary, the burden is on the insurer to prove that assertion with competent evidence such as an independent medical examination, a peer review or other proof that sets forth a factual basis and a medical rationale for denying the claim. (See A.B. Medical Services, PLLC v. Geico Insurance Co., 2 Misc. 3d 26 [App Term, 2nd & 11th Jud Dists 2003]; Kings Medical Supply Inc. v. Country Wide Insurance Company, 783 N.Y.S. 2d at 448 & 452; Amaze Medical Supply, Inc. v. Eagle Insurance Company, 2 Misc. 3d 128 [App Term, 2nd and 11 Jud Dists 2003]).

In the instant matter, Dr. Littman asserts that the EMG/NCV of the lower extremities provided to the Assignor was not medically necessary. Based on review of the medical records, Dr. Littman provides a summary of the

Assignor's history and then provides his analysis for the lack of medical necessity. I find that Dr. Littman has stated a factual basis and medical rationale for his determination that the services provided were not medically necessary. Thus, the burden has shifted to the applicant, who bears the ultimate burden of persuasion.

Where the Respondent presents sufficient evidence to establish a defense based on the lack of medical necessity, the burden then shifts to the Applicant which must then present its own evidence of medical necessity. [see Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11th ed]], Andrew Carothers, M.D., P.C. v. GEICO Indemnity Company, 2008 NY Slip Op 50456U, 18 Misc. 3d 1147A, 2008 N.Y. Misc. LEXIS 1121, West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co. 13 Misc.3d 131, 824 N.Y.S.2d 759, 2006 NY Slip Op51871(U) (Sup. Ct. App. T. 2d Dep't 2006)].

Applicant relies on the rebuttal by Dr. Dimaggio, the records in its submission, and Respondent's records. I find the rebuttal and the records relied on by the Applicant do not adequately address the contentions raised by the peer reviewer.

After a careful review of the evidence and arguments made by the parties at the hearing, I find the Applicant has not established that the EMG/NCV of the lower extremities provided to the Assignor was medically necessary, nor have they rebutted the findings of the peer reviewer. The rebuttal doctor argues that "the Assignor had an obvious presentation of the traumatic lumbar sprain/strain with myofascitis and/or radiculopathy, both of which may cause local and radiating pain and change skin sensation over the involved muscles and in the areas of pain radiation. Differentiating a radiculopathy from a more distal lesion is clinically difficult because the clinical presentation for both conditions is very similar and/or they could coexist." However, the evaluation performed diagnosed the Assignor with radiculopathy. There is no mention anywhere in the 4/24/2019 evaluation that there may be myofascitis and/or why the doctor suspects this to be the case. Nor is there any mention as to why the doctor believes there may be any nerve issue other than radiculopathy. The evaluation states the reason for the "Nerve Conduction studies of the bilateral lower extremities to rule out motor sensory spinal nerve root and peripheral nerve root abnormalities." I find the reason to be vague. It seems based on the evaluation performed that anytime radiculopathy is diagnosed, EMG/NCV needs to be performed to

rule out other nerve root abnormalities. I agree with the peer reviewer that Dr. Dimaggio correctly diagnosed the Assignor with radiculopathy and there was no differential diagnosis requiring further investigation. I find the Respondent has established by a preponderance of the evidence that the EMG/NCV of the lower extremities provided was not medically necessary. Therefore, Applicant's claim is hereby denied.

Regarding the evaluation performed on 4/24/2019, the peer review makes no mention of this evaluation in his peer report. Respondent has not established a basis for denying the evaluation performed under CPT code 99212 in the amount of **\$26.41**. Therefore, I find in favor of the Applicant and hereby award \$26.41 for the evaluation service.

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
	Acupuncture Natural Wellness LLC	03/21/19 - 04/24/19	\$152.76	Withdrawn with prejudice
	Touch Stone Chiropractic P.C.	03/20/19 - 03/29/19	\$104.04	Awarded: \$104.04
	Touch Stone Chiropractic P.C.	04/24/19 - 04/24/19	\$1,102.56	Awarded: \$26.41
Total			\$1,359.36	Awarded: \$130.45

- B. The insurer shall also compute and pay the applicant interest set forth below. 07/28/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Interest runs from the initiation date for this case until the date that payment is made at two percent per month, simple interest, on a pro rata basis using a thirty-day month.

C. Attorney's Fees

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

After calculating the sum total of the first-party benefits awarded in this arbitration plus interest thereon, Respondent shall pay Applicant an attorney's fee equal to 20 percent of that sum total, as provided for in 11 NYCRR 65-4.6(d), subject to a maximum fee of \$1,360.00.

- 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 Suffolk

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

04/30/2021  
(Dated)

Thomas Eck

### **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:**

1bb858795a4e75701d6231fb46556ac8

### **Electronically Signed**

Your name: Thomas Eck  
Signed on: 04/30/2021