American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Medical Care of Western New York (Applicant)	AAA Case No.	17-20-1182-2318
	Applicant's File No.	20-24272
- and -	Insurer's Claim File No.	471035-03AL
	NAIC No.	26077
Lancer Insurance Company (Respondent)		

ARBITRATION AWARD

I, Tasha Dandridge-Richburg, 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: EIP

1. Hearing(s) held on 05/24/2021
   Declared closed by the arbitrator on 05/24/2021

   Nicole Jones, Esq. from The Morris Law Firm, P.C. participated in person for the Applicant

   Lawrence Rogak, Esq. from The Law Office of Lawrence N. Rogak LLC participated in person for the Respondent

2. The amount claimed in the Arbitration Request, **$ 12,100.94**, 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 68 year-old EIP was a passenger on a bus that was involved in an accident on February 19, 2019. At issue in this case is $12,100.94 for physical therapy treatments directed to the EIP's cervical spine and bilateral shoulders on dates of service from June 6, 2020 to September 23, 2020. Respondent argues that many of the bills were not received within 45 days. All the other bills were timely denied based upon an independent medical examination (IME) conducted by Steven Hausmann, MD on January 21, 2020.

4. Findings, Conclusions, and Basis Therefor

Pursuant to 11 NYCRR §65-4.5(o)(1), 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. This Award is based upon a review of all of the documents contained within the ADR Center electronic case file as of the date of the Award, as well as upon any oral arguments by or on behalf of the parties and any testimony given during the hearing.

45 DAY RULE DEFENSE

Respondent argues that the bills for dates of service: February 24, 2020; March 5, 2020; March 9-11, 2020; April 1, 2020; April 7, 2020; and September 14, 2020 were not received within 45 days as is required by regulation. Instead they were received with Applicant's AR1.

Analysis

An applicant establishes a *prima facie* showing of entitlement to No-Fault benefits by submitting evidentiary proof that the prescribed statutory billing forms setting forth proof of the fact and amount of loss sustained were mailed and received by the insurer and that No-Fault benefits are overdue. *Viviane Etienne Medical Care v. Country-Wide Ins. Co.*, 25 N.Y.3d 498 (2015). *See also, Sunshine Imaging Assn./WNY MRI v. Government Empls. Ins. Co.*, 66 A.D.3d 1419 (App. Div., 4th Dept., 2009).

Written proof of claim must be submitted to an insurer no later than forty-five (45) days after the date the services were rendered unless written proof is submitted providing clear and reasonable justification for the failure to comply. 11 NYCRR 65-1.1.

Applicant argued that Respondent issued a general denial of treatment, including physical therapy treatments based upon Dr. Hausmann' IME and pursuant to *State Farm v Domotor*, 266 A.D.2d 219, 220, 697 N.Y.S.2d 348, 349 (2d Dept. 1999), Applicant was no longer required to timely submit its bills. *State Farm Ins. Co. v. Domotor*, provides, "[o]nce an insurer repudiates liability . . . the [in]sured is excused from any of its obligations under the policy." Therefore, Applicant was not required to submit the bill in a timely manner.

I find that *Domotor* applies. Accordingly, following the issuance of a denial based upon an IME, Applicant was no longer required to timely submit its bills. Therefore, Respondent's 45 day rule defense cannot be sustained.

DR. HAUSMANN'S IME

On January 21, 2020, Dr. Hausmann conducted an orthopedic re-examination of the EIP. Dr. Hausmann previously examined the EIP on August 20, 2019. Dr. Hausmann's January 21, 2020 examination of the EIP's cervical spine revealed the following ranges of motion: 30/40 degrees of flexion, 40/75 degrees of extension, ad 45/70 degrees of left and right rotation. Examination of the EIP's lumbar spine revealed the following ranges of motion: 50/90 degrees of flexion, 20/20 degrees of extension, 45/60 degrees of right and left rotation, and mild restriction of side bending. Dr. Hausmann's diagnosis was cervical myofascial strain with exacerbation of multi-level cervical degenerative disc disease, orthopedically resolved and lumbar myofascial strain with exacerbation of multi-level lumbar degenerative disc disease, orthopedically resolved. Following his examination and review of records, Dr. Hausmann concluded as follows:

> This gentleman still has limited range of motion. I would note that his physical exam findings are not consistent with any functional improvement. This would include somewhat worse range of motion when compared to what I saw when I evaluated him last.
> I would note that he was under care of a physiatrist, which is outside the area of expertise of orthopedic surgery and he has not been seen by an orthopedic surgeon. He has been attending physical therapy continuously, once again, without any demonstrated functional improvement.
> With the above facts in mind, it would be my opinion that the diagnosed conditions are causally related to the accident.
> At this point, it is my belief that he does not require any further formal physical therapy. He has had an adequate program of physical therapy relative to the diagnosed conditions. Further physical therapy would not be indicated given the lack of functional improvement.
> This claimant had pre-existing cervical and lumbar degenerative disc disease, which had an impact on his recovery. The claimant is disabled from a prior head injury. He is not disabled due to this accident. He has been out of work for a number of years and there is no expectation for this man to return to work although I have no specific restrictions for him relative to this accident.
> Based on today's examination and review of records, there is no surgical indication. He has no disc syndrome or radicular syndrome. There has been no recommendation for surgery and no evaluation via spine surgeon has been obtained by the treating doctor.
> Again, given the lack of any radicular findings or findings consistent with a disc syndrome or radicular syndrome, I do not recommend any surgery relative to this claim.
> This claimant does not require transportation services or additional diagnostic testing. He also does not require any household help or ambulatory services.

Analysis

Once an applicant has established a prima facie case of entitlement to No-Fault benefits, the burden then shifts to the insurer to prove that the disputed services were not medically necessary. To meet this burden, the insurer's denial(s) of the applicant's claim(s) must be based on a peer review, IME report, or other competent medical evidence that sets forth a clear factual basis and a medical rationale for the denial(s). *Amaze Medical Supply, Inc. v. Eagle Ins. Co.*, 2 Misc. 3d 128A (App. Term, 2nd Dept., 2003); *Tahir v. Progressive Cas. Ins. Co.*, 12 Misc. 3d 657 (N.Y.C. Civ. Ct., N.Y. Co., 2006); *Healing Hands Chiropractic, P.C. v. Nationwide Assurance Co.*, 5 Misc. 3d 975 (N.Y.C. Civ. Ct., N.Y. Co., 2004); *Millennium Radiology, P.C. v. New York Cent. Mut.*, 23 Misc. 3d 1121(A) (N.Y.C. Civ. Ct., Richmond Co., 2009); *Beal-Medea Prods., Inc. v GEICO Gen. Ins. Co.*, 27 Misc. 3d 1218(A) (N.Y.C. Civ. Ct., Kings Co., 2010); *All Boro Psychological Servs., P.C. v GEICO Gen. Ins. Co.*, 34 Misc. 3d 1219(A) (N.Y.C. Civ. Ct., Kings Co., 2012).

I find that Hausmann's IME fails to set forth a clear factual basis and a medical rationale for Respondent's denials of Applicant's claims for the physical treatments in dispute herein and as such, I find that Respondent has failed to establish a lack of medical necessity for same. The physical therapy treatments at issue herein were primarily focused upon the EIP's cervical spine and bilateral shoulders. Dr. Hausmann did not examine the EIP's shoulders and provided no opinion as to whether further treatment directed to the shoulders would be medically necessary. Further, Dr. Hausmann's examination of the cervical spine revealed reduced ranges of motion. I am not convinced that further treatment would be medically unnecessary based upon Dr. Hausmann's report. Therefore, Respondent's denials cannot be upheld.

I note that no arguments were made based upon the Workers' Compensation Fee Schedule.

Accordingly, I find for Applicant.

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**
	Medical Care of Western New York	**02/06/20 - 09/23/20**	**$12,100.94**	**Awarded: $12,100.94**
Total			**$12,100.94**	**Awarded: $12,100.94**

B. The insurer shall also compute and pay the applicant interest set forth below. 10/21/2020 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 particular denial at issue was timely. *LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co.*, 12 N.Y.3d 217 (2009).

C. Attorney's Fees

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

Applicant is awarded statutory attorney fees pursuant to the no-fault regulations. *See*, 11 NYCRR §65-4.5(s)(2). The award of attorney fees shall be paid by the insurer. 11 NYCRR §65-4.5(e). Accordingly, "the attorney's fee shall be limited as follows: 20 percent of the amount of first-party benefits, plus interest thereon, awarded by the arbitrator or the court, subject to a maximum fee of $1360." Id. However, if the

benefits and interest awarded thereon is equal to or less than the respondent's written offer during the conciliation process, then the attorney's fee shall be based upon the provisions of 11 NYCRR 65-4.6(b).

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 Erie

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

05/25/2021
(Dated)

Tasha Dandridge-Richburg

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:
adff79cf2fefd19f9f2e11b05c470f17

Electronically Signed

Your name: Tasha Dandridge-Richburg
Signed on: 05/25/2021