American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Metropolitan Medical and Surgical, P.C. (Applicant)	AAA Case No.	17-20-1177-0402
	Applicant's File No.	49642
- and -	Insurer's Claim File No.	0676657010000002
	NAIC No.	35882
Geico Insurance Company (Respondent)		

ARBITRATION AWARD

I, Aaron Maslow, 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 ["BO"]

1. Hearing(s) held on 07/19/2021
   Declared closed by the arbitrator on 07/19/2021

   The Law Offices of John Gallagher, PLLC from The Law Offices of John Gallagher, PLLC participated by written submission for the Applicant

   GEICO Insurance Company from GEICO Insurance Company participated by written submission for the Respondent

2. The amount claimed in the Arbitration Request, **$ 984.53**, 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

   - Whether Applicant established entitlement to No-Fault insurance compensation for an office visit, trigger point injections, a cervical epidural steroid injection, and an epidurography performed to treat Assignor.

   - Whether Respondent made out a prima facie case of lack of medical necessity and, if so, whether Applicant rebutted it.

   - Whether fees were not in accordance with fee schedule.

4. Findings, Conclusions, and Basis Therefor

Appearances

For Applicant:

The Law Offices of John Gallagher, PLLC
9707 3rd Avenue
2nd Floor, Suite A
Brooklyn, NY 11209

For Respondent:

GEICO Insurance Company
750 Woodbury Road
Woodbury, NY 11797

Applicant commenced this New York No-Fault insurance arbitration, seeking as compensation $984.53 which it billed for performing an office visit, trigger point injections, a cervical epidural steroid injection, and an epidurography to treat Assignor, a 41-year-old male, who was injured in a motor vehicle accident on Feb. 19, 2020. The date of service was June 12, 2020. Respondent denied payment on two grounds: fees not being in accordance with fee schedule and lack of medical necessity.

This arbitration was organized by the American Arbitration Association, which has been designated by the New York State Department of Financial Services to coordinate the mandatory arbitration provisions of Insurance Law § 5106(b), which provides:

> Every insurer shall provide a claimant with the option of submitting any dispute involving the insurer's liability to pay first party ["No-Fault insurance"] benefits, or additional first party benefits, the amount thereof or any other matter which may arise pursuant to subsection (a) of this section to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent.

This arbitration was scheduled for a hearing to take place on July 19, 2021. Rule a of the Rules for Arbitration of No-Fault Disputes in the State of New York, promulgated by the American Arbitration Association (AAA), and 11 NYCRR 65-4.5(a) in the New York No-Fault Regulations both provide: "At the arbitrator's discretion, if the dispute involves an amount less than $2,000, the parties shall be notified that the dispute shall be resolved on the basis of written submissions of the parties." On May 6, 2021, the undersigned arbitrator entered a determination in this

case's Electronic Case Folder that the instant dispute would be resolved on the basis of the written submissions of the parties. This was subsequently conveyed to the parties by AAA, who informed them that no live hearing would be conducted.

I have reviewed the submissions' documents contained in the American Arbitration Association's ADR Center as of June 9, 2021, said submissions constituting the record in this case. This date was set as the cutoff date for any late submissions in the May 6, 2021 determination. Any late submissions on or prior to June 9, 2021 have been considered. Any submitted afterwards have not. This is pursuant to 11 NYCRR 65-4.2(b)(3)(iv), which vests discretion in the arbitrator to determine whether documents which otherwise would be excluded from the record due to lateness by virtue of 11 NYCRR 65-4.2(b)(3)(i)-(iii) should be considered.

"[A] plaintiff demonstrates prima facie entitlement to summary judgment by submitting evidence that payment of no-fault benefits are overdue, and proof of its claim, using the statutory billing form, was mailed to and received by the defendant insurer." Viviane Etienne Medical Care, P.C. v. Country-Wide Ins. Co., 25 N.Y.3d 498, 501 (2015). "The court may, in its discretion, rely on defendant's documentary submissions establishing defendant's receipt of plaintiff's claims [citation omitted]." Lenox Hill Radiology MIA, P.C. v. American Transit Ins. Co., 19 Misc.3d 358, 363 (Civ. Ct. New York Co. 2008). An insurer's denial of claim form indicating the date on which it was received adequately establishes that the claimant sent, and that the defendant received, the claim. Ultra Diagnostics Imaging v. Liberty Mutual Ins. Co., 9 Misc.3d 97 (App. Term 9th & 10th Dists. 2005). Respondent's denial of claim acknowledged receipt of Applicant's proof of claim and proved nonpayment of the bill embodied therein. Hence, I find that Applicant established a prima facie case of entitlement to No-Fault compensation.

Respondent's denial of claim was timely issued, i.e., within the 30-day deadline prescribed by Insurance Law §5106(a) and 11 NYCRR 65-3.8(a)(1). As such, it was within its rights to assert lack of medical necessity as a defense. Liberty Queens Medical, P.C. v. Liberty Mutual Insurance Co., 2002 WL 31108069 (App. Term 2d & 11th Dists. June 27, 2002); cf. Country-Wide Insurance Co. v. Zablozki, 257 A.D.2d 506 (1st Dept. 1999). "The no-fault law defines 'basic economic loss,' for which accident victims are entitled to reimbursement up to $50,000, as '[a]ll *necessary* expenses incurred for: (i) medical, hospital ... surgical, nursing, dental, ambulance, x-ray, prescription drug and prosthetic services' (Insurance Law § 5102[a][1] [emphasis added]). Like the statute, the regulations promulgated thereunder expressly state that reimbursable medical expenses consist of '*necessary* expenses' (11 NYCRR 65-1-1 [emphasis added])." Long Island Radiology v. Allstate Ins. Co., 36 A.D.3d 763, 765 (2d Dept. 2007).

A peer review report relied upon by an insurer in timely denying a claim is a proper vehicle to assert the defense of lack of medical necessity. S & M Supply, Inc. v. Allstate Ins. Co., 2003 N.Y. Slip Op. 51191(U) (App. Term 2d & 11th Dists. July 9, 2003); Rockaway Boulevard Medical P.C. v. Travelers Property Casualty Corp., 2003 N.Y. Slip Op. 50842(U) (App. Term 2d & 11th Dists. Apr. 1, 2003). In fact, without a peer review, a defense of lack of medical necessity at the litigation stage

cannot survive. See A.B. Medical Services PLLC v. Lumbermens Mutual Casualty Co., 4 Misc.3d 86 (App. Term 2d Dept. 2004).

A peer reviewer must establish a factual basis and medical rationale for his asserted lack of medical necessity of the health care provider's services. See Amaze Medical Supply Inc. v. Allstate Ins. Co., 12 Misc.3d 142(A), 2006 N.Y. Slip Op. 51412(U) (App. Term 2d & 11th Dists. July 12, 2006); Prime Psychological Services, P.C. v. Progressive Casualty Ins. Co., 24 Misc.3d 1244(A), 2009 N.Y. Slip Op. 51868(U) at 3 (Civ. Ct. Richmond Co., Katherine A. Levine, J., Aug. 5, 2009); A.M. Medical Services, P.C. v. Deerbrook Ins. Co., 18 Misc.3d 1139(A), 2008 N.Y. Slip Op. 50368(U) (Civ. Ct. Kings Co., Sylvia G. Ash, J., Feb. 25, 2008).

"A no-fault insurer 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 / professional practice. The opinion of the insurer's expert, standing alone, is insufficient to carry the insurer's burden of proving that the services were not 'medically necessary'." CityWide Social Work & Psy. Serv., P.L.L.C. v. Travelers Indemnity Co., 3 Misc.3d 608, 609 (Civ. Ct. Kings Co. 2004). "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." Id. at 616; accord, Prime Psychological Services, P.C. v. Progressive Casualty Ins. Co., supra; Millennium Radiology, P.C. v. New York Central Mutual Fire Ins. Co., 23 Misc.3d 1121(A), 2009 N.Y. Slip Op. 50877(U) (Civ. Ct. Richmond Co., Katherine A. Levine, J., Apr. 30, 2009). Without a recitation to generally accepted medical practice, a peer reviewer's opinion is simply a different professional judgment which, in and of itself, does not establish that the disputed services were medically unnecessary to treat the injured person's condition.

If the peer review satisfies these standards, it becomes incumbent on the claimant to rebut the peer review. See Be Well Medical Supply, Inc. v. New York Cent. Mut. Fire Ins. Co., 18 Misc3d 139(A), 2008 N.Y. Slip Op. 50346(U) (App. Term 2d & 11th Dists. Feb. 21, 2008); A Khodadadi Radiology, P.C. v. NY Central Mutual Fire Ins. Co., 16 Misc.3d 131(A), 2007 N.Y. Slip Op. 51342(U) (App. Term 2d & 11th Dists. July 3, 2007), because the ultimate burden of proof on the issue of medical necessity lies with the claimant. Dayan v. Allstate Ins. Co., 49 Misc.3d 151(A), 2015 N.Y. Slip Op. 51751(U) (App. Term 2d, 11th & 13th Dists. Nov. 30, 2015); Park Slope Medical and Surgical Supply, Inc. v. Travelers Ins. Co., 37 Misc.3d 19, 22 n. (App. Term 2d, 11th & 13th Dists. 2012).

"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 (see Prince, Richardson on Evidence §§ 3-104, 3-202 [Farrell 11th ed])." West Tremont Medical Diagnostic, P.C. v. Geico Ins. Co., 13 Misc.3d 131(A), 2006 N.Y. Slip Op. 51871(U) at 2 (App. Term 2d & 11th Dists. Sept. 29, 2006). Thus, although

Respondent must come forward with prima facie proof of lack of medical necessity, the burden will shift to Applicant to prove medical necessity by a preponderance of the credible evidence if Respondent meets its burden.

Dr. Jay Weiss wrote the peer review relied upon by Respondent. He noted that several examinations revealed no radiating neck pain and that strength, sensation, and reflexes were normal. Given this clinical picture without significant persistent evidence of cervical nerve root compromise, a cervical epidural injection would not be indicated. If the injection is not necessary, related imaging including epidurogram as well as medication, supply, facility or anesthesia services would not be necessary. With regard to trigger point injections, if actual trigger points were present these should generally be treated prior to performing any procedure as invasive as cervical epidural injection, particularly given the lack of any persistent radicular component to the pain. Also, it was not noted in clinical findings which side the trigger points were on let alone at which levels.

I find that Dr. Weiss had a more than adequate factual basis for is peer review. He listed numerous medical records pertaining to Assignor's post-accident treatment which he reviewed. His peer review also contained a medical rationale in that he conveyed that generally accepted medical practice was applied. He did so by citing to various medical authorities for the propositions advanced. With respect to the services other than the office visit, Dr. Weiss's conclusion f lack of medical necessity was amply supported.

There is no formal rebuttal from Applicant. I reviewed the examination reports. I find them insufficient to justify the injections. Moreover, the EMG/NCV report in the record evidenced no cervical radiculopathy. As such, epidural steroid injections are not called for. Indeed, the locations of the trigger points were not in Applicant's examination reports.

With respect to the trigger point injections, cervical epidural steroid injection, and epidurography, I find a lack of medical necessity. The defense to that effect, asserted in Respondent's denial of claim is sustained; it overcomes Applicant's prima facie case of entitlement to No-Fault compensation.

Applicant's prima facie case of entitlement to No-Fault compensation stands with respect to the office visit as Dr. Weiss did not opine on it. The $50.22 fee is proper; I reject the defense of fees not being in accordance with fee schedule.

Any issue as to fees charged for the trigger point injections, cervical epidural steroid injection, and epidurography is academic.

The within arbitration claim is granted to the extent of awarding Applicant $50.22 in health service benefits.

This arbitrator has not made a determination that benefits provided for under Article 51 (the No-Fault statute) of the Insurance Law are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the

actions or conduct of Assignor. As such and in accordance with the provisions of the prescribed NYS Form NF-AOB (the assignment of benefits), Applicant health provider shall not pursue payment directly from Assignor for services which were the subject of this arbitration, notwithstanding any other agreement to the contrary.

Interest: Where a claim is timely denied, interest shall begin to accrue as of the date arbitration is requested by the claimant, i.e., the date the American Arbitration Association (AAA) receives the applicant's arbitration request, unless arbitration is commenced within 30 days after receipt of the denial, in which event interest shall begin to accrue as of the 30th day after proof of claim was received by the insurer. 11 NYCRR 65-4.5(s)(3), 65-3.9(c); Canarsie Medical Health, P.C. v. National Grange Mut. Ins. Co., 21 Misc.3d 791, 797 (Sup. Ct. New York Co. 2008) ("The regulation provides that where the insurer timely denies, then the applicant is to seek redress within 30 days, after which interest will accrue.") The plaintiff health care provider in Canarsie Medical Health, P.C. argued that where a timely issued denial is later found to have been improper, the interest should not be stayed merely because the provider did not seek arbitration within 30 days after having received the denial. The court rejected this argument, finding that the regulation concerning interest was properly promulgated; this includes the provision staying interest until arbitration is commenced where the claimant does not promptly take such action. Applicant presumptively received Respondent's denial a few days after July 16, 2020, when it was issued. Applicant's arbitration request was received by the AAA on Aug. 28, 2020, which was more than 30 days later. Thus, interest must accrue from that date, not from the 30th day after proof of claim was received by Respondent. The end date for the calculation of the period of interest shall be the date of payment of the claim. In calculating interest, the date of accrual shall be excluded from the calculation. General Construction Law § 20 ("The day from which any specified period of time is reckoned shall be excluded in making the reckoning.") Where a motor vehicle accident occurs after Apr. 5, 2002, interest shall be calculated at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month. 11 NYCRR 65-3.9(a); Gokey v. Blue Ridge Ins. Co., 22 Misc.3d 1129(A), 2009 N.Y. Slip Op. 50361(U) (Sup. Ct. Ulster Co., Henry F. Zwack, J., Jan. 21, 2009).

Attorney's Fee: 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) (as existing on the filing date of this arbitration), subject to a maximum fee of $1,360.00.

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Please note that the Modria template for New York No-Fault arbitration awards contains an unalterable preprinted entry below for the State of New York, County of _____ as the location where the award was executed. This award was executed in the State of Florida, County of Palm Beach.

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**
	Metropolitan Medical and Surgical, P.C.	**06/12/20 - 06/12/20**	**$984.53**	**Awarded: $50.22**
Total			**$984.53**	**Awarded: $50.22**

B. The insurer shall also compute and pay the applicant interest set forth below. 08/28/2020 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

   Respondent shall pay Applicant interest on the total first-party benefits awarded herein, computed from Aug. 28, 2020 to the date of payment of the award, but excluding Aug. 28, 2020 from being counted within the period of interest. The interest rate shall be two percent per month, simple (i.e., not compounded), on a pro rata basis using a 30-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) (as existing on the filing date of this arbitration), 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 State of Florida, County of Palm Beach

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

07/19/2021
(Dated)

Aaron Maslow

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:
9f0025793a56e031ca99c56586d97fe0

Electronically Signed

Your name: Aaron Maslow
Signed on: 07/19/2021